Sports Claim Form

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6 Lloyd's Avenue
London
EC3N 3AX

Tel: 0870 142 0871 Fax: 0870 142 0872

Email: sportsclaims@lroinsurance.co.uk

IMPORTANT NOTE

We aim to provide you with prompt and careful handling of your claim. To help us to help you please ensure that all relevant questions are answered as fully as possible (continue your answers on a separate page if necessary).

In addition you should:

- Contact your insurance broker if you need assistance
- Provide all documentation in support of your claim, such as medical certificates, but do not delay submitting this form if such documents are not immediately available
- Complete the form clearly and in BLOCK CAPITALS

Applicant Details

Policy number

Insuring broker

Club name

League name

Club Secretary

Postal address

Postcode

Telephone

Email

Insured Person (Claimant) Details

Insured person

Postal address

Postcode

Telephone

Email

Occupation

Date of birth

Insured person's representative

Postal address

Postcode

Telephone

Email

Claimant Details Continued

Date accident occurred?

Where did it occur?

State how the accident occurred: **(Continue on a separate sheet if necessary)**

Details of injuries sustained: **(Continue on a separate sheet if necessary)**

Please state the following as applicable:

1. The date from which you have been unable to attend to your occupation:
2. The date on which you were able to return to your occupation:
3. The date on which you expect to return to your occupation:

Note: You should submit any medical certificates Issued by your doctor in support of your claim.

Have you ever suffered from a similar injury or disability in the past? ◯ Yes ◯ No

If, YES, Please provide details:

Name and Address of Doctor who attended to you:

Name and Address of your usual Doctor:

When did you first seek medical attention in respect of your injury or disability:

What is the amount that you are claiming?

Hospital Statement

- **Only to be completed if claiming Hospitalisation Benefit or Fracture Benefit (as indicated in your Policy Schedule or Wording if applicable)**
- **This section must be completed by hospital medical staff or admissions**
- **Any fee for the completion of this section is the responsibility of the Claimant**

Type of Hospital/Ward:

Name of Doctor or Consultant in charge:

On what date was the patient: Admitted: Discharged:

Was the patient in a comatose state at any time? ◯ Yes ◯ No

If, YES, Please state: From: To:

If the patient had sustained a fracture please specify the fractured bone(s) and severity:

Please provide any additional information that you feel is relevant:

Signed: Position held in hospital:

Date: Qualifications:

Please use validation stamp or complete in **BLOCK CAPITALS**:

Hospital Name & Address:

Postcode **Telephone**

Data Protection

By signing this Claim Form you consent to W.R. Berkley Insurance (Europe), Limited using the information we may hold about you for the purpose of providing insurance, handling claims and to process sensitive data about you where this is necessary (for example health information). This may mean we have to give some details to third parties involved in providing insurance cover. These may include insurance carriers, third-party claims adjusters, fraud detection and preventions services, reinsurance companies and insurance regulatory authorities. Where such sensitive personal information relates to anyone other than you, you must obtain the explicit consent of the person to whom the information relates both to the disclosure of such information to us and its use by us as set out above. The information provided will be treated in confidence and in compliance with the Data Protection Act 1998. You have the right to apply for a copy of your information (for which we may charge a fee) and to have any inaccuracies corrected.

Doctors Statement

- **This Section must be fully completed by the attending Doctor or your usual Doctor**
- **Any fee for the completion of this section is the responsibility of the Claimant**

Patient's full name:

Date of birth: Height: Weight:

Are you the patient's usual medical attendant? ◯ Yes ◯ No If, YES, Since when?

Please give full details of the patient's injury: **(Continue on a separate sheet if necessary)**

When did the patient first receive medical attention for this injury:

Has the patient ever suffered with this or any similar injury or condition previously? ◯ Yes ◯ No

Please give full details of the patient's injury: **(Continue on a separate sheet if necessary)**

Please state the following as applicable:

1. The date the patient became unable to attend to their usual occupation;
2. The date the patient was able to return to their usual occupation:
3. The date on which you expect the patient to be able return to their occupation:

Was the patient hospitalised as a result of their injury ◯ Yes ◯ No

Please provide any additional information that you feel is relevant:

Signed: Position held in hospital:

Date: Qualifications:

Please use validation stamp or complete in **BLOCK CAPITALS**:

Hospital Name & Address:

Postcode **Telephone**

Witness Statement

- We require a statement from anyone who witnessed your accident. Please have that person complete this section.

Witness's Name:

Postal address:

Postcode **Telephone**

Email

Please give full details of the patient's injury: **(Continue on a separate sheet if necessary)**

Signed: Date:

Official Report

- To be completed by Club Secretary or Treasurer.

Name:

Postal address:

Postcode **Telephone**

Email

Name of club:

Was the player listed above registered at the time of the accident? ◯ Yes ◯ No

If, YES, Please give details

Registration Number: Date of Registration:

Were you a witness to the accident described? If yes please provide details of the event

Please provide a copy of the:

- Team Sheet
- Score sheet where the details of the accident have been recorded

DECLARATION OF CLUB OFFICIAL

I Clarify that the particulars shown on this form by the player are to the best of my belief and knowledge, true and correct.

Signed: Date:

Law Applicable

We require completion of a medical report by your attending doctor. Before your attending doctor can give a medical report you must give your consent. Before giving your consent you should be aware of your rights under the Access to Medical Record Act 1988 which are summarised below:

1. You may withhold consent.
2. You may see the report before it is sent to us within 21 days from the date of the report.
3. You may ask to see the report for up to six months after the report is completed.
4. You may ask the doctor to amend and part of the report which you consider to be incorrect or misleading. If the doctor does not agree with your request you may attach your comments to the report.

Please note: The doctor may withhold all or part of the report from you if he considers that you may be physically or mentally harmed by it.

PATIENT DECLARATION

I have been made aware of my statutory rights under the Access to Medical Records Act 1988 in connection with my claim.

1. I hereby consent to W.R. Berkley Insurance (Europe), Limited seeking medical information from any doctor who at any time has attended me concerning anything which affects my physical or mental health.
2. Please tick as appropriate:

- ◯ **I DO wish to see the report before it is sent to W.R. Berkley Insurance (Europe), Limited**
- ◯ **I DO NOT wish to see the report before it is sent to W.R. Berkley Insurance (Europe), Limited**

3. I authorise such doctor to disclose such information to W.R. Berkley Insurance (Europe), Limited.
4. I agree that a copy of this consent shall have the validity of the original.

Signature _____ Date * 06/07/11

Declaration

I declare all the information given above to be true and complete to the best of my knowledge and belief.

Name: _____

Signature _____ Date * 06/07/11

Print Form Submit by Email

IN ORDER TO AVOID DELAY IN HANDLING YOUR CLAIM PLEASE ENSURE THAT:

- You have fully answered all relevant questions before your doctor completes their statement.
- You have enclosed all requested information and documentations.
- You have signed the Access to Medical Records section and the Declaration.
- Your doctor fully completes the statement.

ONCE COMPLETE PLEASE SEND THIS FORM TO YOUR INSURANCE BROKER