HCC International Insurance Company PLC

40 Lime Street, London EC3M 5BS

Claim Form

All England Netball Association Limited

Personal Accident

Policy Number - B0901L61209694

Important Notice

Please ensure that each question is answered fully and accurately

	Checklist (please tick)
▪ Section 1A and 1B – to be completed by the individual submitting the claim	☐
▪ Section 2 – to be completed by a qualified and registered medical practitioner (at the claimant's own expense)	☐
▪ Please ensure that Section 1 is **signed** by the individual making the claim, **and** Section 2 is signed by the registered medical practitioner	☐

Once both sections have been fully completed please return the form to

Membership Dept
England Netball
1-12 Old Park Road
Hitchin
Herts SG5 2JR
T: +44 (0)1462 442344
F: +44 (0)1462 442343
E: affiliations@englandnetball.co.uk

A copy of this claim form should be retained by you for your records

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The following questions relate to the person submitting the claim

If there is insufficient space to answer questions, please use an additional sheet and attach it to this form (please indicate section number)

Name of Insured Individual:_____ Affiliation Number:_____

Address:
_____
_____
_____

Date of Birth: _____

Occupation: _____

Telephone: _____ E-Mail address: _____

Club ID/Name: _____ Weekly Income:_____

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Section 1A

Claim Accident Background (to be completed by the claimant)

1. Please state Location, Date and Time of Accident and attach the umpired match report recording the accident

Location / Event:	
Date:	Time:

.2. In what capacity were you playing Netball:
(*please tick relevant box and provide qualification if applicable).*

Player			
Coach		Qualification:	
Umpire		Qualification:	

3 Please give a full description of the accident and circumstances surrounding it including weather conditions and team name of opposition (please complete on a separate sheet if necessary)

4 Please state, as precisely as you can, the injuries you have sustained

5 Did you receive any 'on field' treatment / diagnosis at the event? Yes / No
If Yes, please give full details

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6. Were you hospitalised as a result of this accident?
If Yes, please provide name of hospital, date and time of your admission and a copy of your hospital discharge form.

Yes / No

7. Have you any previous history of an injury similar to that now sustained?
If Yes, please give full details (on a separate sheet if necessary)

Yes / No

8. As a result of this accident, have you been unable to attend to any part of your occupation?

Yes / No

If the answer is 'Yes; (I) Are you still so incapacitated and (II) between which dates have you been incapacitated

(I)

Details:

(II)

9. Are you claiming under any other policy in respect of this accident?
If yes, please give full details

Yes / No

Section 1B

Information concerning the duration of your Accident

(to be completed by the claimant)

10. Period of Temporary Total Disablement?

11. Give date that normal occupation was resumed?

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12. Are you receiving any ongoing physiotherapy treatment as a result of this accident? Yes / No
If Yes, please provide full details

13. Has any Permanent Disablement resulted? Yes / No
If yes, please give full details

14. Parental Travel Expenses (Under 16s only)
Please give details of expenses, providing receipts where possible.

Declaration (to be made by the claimant)

Important

I hereby authorise any hospital, physician or other person who has attended or examined me, to furnish the company or its authorise representative all information with respect to any illness or injury, medical history, consultation, prescriptions or treatment and copies of all hospital records.

I also agree to be medically examined by an authorised representative of my insurers, if required by them. A Photostat copy of this authorisation shall be considered as effective and valid as the original.

I/ We declare that the above particulars are true in every respect.

Claimant's Signature: | Print Name: | Dated:

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Section 2

Medical Certificate (to be completed by a registered medical practitioner)

Name of Doctor:	Name of Claimant:

Practice Address:

_____

_____

_____

Telephone: _____ E-Mail address: _____

1. When did you first attend upon the claimant in consequence of the injuries/illness sustained?

Location / Event:	Date:

2. Are you still in attendance? Yes / No

3. Are you the usual medical attendant of this patient? Yes / No
   If Yes, how long have you known him / her years

4. What was the cause of the accident so far as known?

5. What injuries were sustained?

   i) Region injured (if a hand, arm, foot, or leg, state whether right or left)

   ii) Outline the nature and extent of injuries

6. Are the symptoms from which he/she suffers due to:

   i) The accident alone, or

   ii) Are they attributable to any other cause

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7. Is the patient now, or was he/she at the time of the accident / illness subject to or suffereing from any illness or disease irrespective of the accident for which the benefit is claimed?
If Yes, please state the nature of same, and to what extent the recovery of the patient may be Affected thereby.

Yes / No

8. If you are the usual medical attendant of the patient, are you aware of anything in his/her previous medical history which might have contributed directly or indirectly to the occurrence of the accident or which may be likely to retard in any way recovery from it?

9. Are you prepared to certify that the patient is totally disabled from attending to any portion of his/her occupation?

10. For what period has the claimant been totally disabled from any part of his/her occupation?

Declaration (to be made by the medical practitioner)

a) I warrant that that this form and questionnaire has been completed to the best of my knowledge and belief that all statements and particulars provided by me are true and complete.
b) I have NOT misstated, omitted, or suppressed any material fact or information (a material fact is one which is likely to influence an Underwriter's assessment and acceptance of a claim. If you are in any doubt as to whether a fact is material or not you are advised that it is in your own interest to disclose all facts).
c) If there is any material alteration to the facts or information which I have provided or any new material matter arises, I undertake to inform Insurers.

Doctor's Signature: Print Name: Dated:

Address:

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