Cumann Peil Gael na mBan

The Ladies Gaelic Football Association

PRELIMINARY CLAIM FORM

To be received within eight weeks of the date of injury.

N.B PERMISSION MUST BE SOUGHT FROM THE INJURY FUND CO-ORDINATOR FOR ALL PRIVATE TREATMENT PRIOR TO RECEIVING THE TREATMENT.

Name of injured party:

Address:

Date of Birth:

Club:

Player registration number

Telephone Number:

Email Address:

Employment Status *(Please tick as appropriate)*

Student ☐ Employed ☐ Self Employed ☐ Unemployed ☐

Private Medical Insurance: Yes ☐ No ☐

Vhi Insurance: Yes ☐ No ☐

Aviva Hibernian Insurance: Yes ☐ No ☐

Medical Card No:

Quinn Insurance: Yes ☐ No ☐

Other Insurance: *(Please Specify)*

Date of Injury:

Time of Injury:

Nature of Injury:

Brief Details of how injury occurred:

Injury occurred at the following:

Club:

Training: Yes ☐ No ☐

Game: Yes ☐ No ☐

County:

Training: Yes ☐ No ☐

Game: Yes ☐ No ☐

Signature of Injured Party:

Date:

Signature of Parent/Guardian of Under 18 player:

Date:

Signature of Club Secretary:

Date:

Signature of County Secretary:

Date: