WFA PERSONAL ACCIDENT REPORT FORM

Please fully complete this claim form, including the signed declaration on the final page, please provide any additional information which you have in support of your claim including medical certificates (Sick Note), photographs etc

- Supporting Documents must be provided to progress the claim
- Completed claim must be submitted within 90 days

Have you enclosed?

Hospital Discharge notes	Yes / No
Medical Certificate (Sick Note)	Yes / No

*this required if you are unable to return to employment even if you are self employed

Photographs	Yes / No
Copy/Photo of membership	Yes / No
Copy of incident report from venue	Yes No

if no, please explain

About the Injured Person

Full Name of Injured Person	
Address	
Date of Birth	
Contact Person (if not the injured person) Relationship e.g. Parent	
Contact Telephone No	
Email Address	
Sex	Male / Female
Amateur or Professional	Amateur / Professional
If Amateur, please confirm Occupation	
Club if applicable	
Affiliation to WFA	Player / Coach / Referee / Official

About the Accident	
Date of the Event where the Accident occurred	
Location of the Event where the Accident occurred	
Was the Event covered by Permit	Yes / No
Name of the Organising Club if applicable	
Type of Event	
Details of the injury suffered	
How did the injury occur?	
What were you doing when the injury occurred?	

Treatment	
Name, Address and Telephone Number of the Doctor from Whom Treatment has been sought	
Did the Injured Person attend hospital? If Yes what time arrived at hospital	Yes / No
Was the Injured Person detained in Hospital?	Yes / No
If yes, please provide: Name of Hospital Address of Hospital When was the injured person released from hospital? Please including approx. times of admission and discharge	

* Supporting evidence will be required e.g. discharge notes (without this claims will not be processed)

Injured Person Employment Details	
Please confirm employment status:	Full / Part Time Employment Self Employed Full Time Education
Please provide the name, address and telephone number of your employer if applicable	
On what date did you or do you expect to resume work / education?	

Details of Other Insurance	
Is the Injured Person covered under any other health / personal accident insurance?	
If Yes, please provide the name, address and telephone number of the Insurance Company and/or Broker	
Please list all policies held by you, your employer, spouse or parents under which you are covered	

Medical Certificate – If you are unable to return to your usual occupation / employment (excluding education) after 14 days Excess Period ***To be completed by the Claimant's usual GP at the Claimant's own expense*** **Not required for students / in full time education / retired / out of work**	
Claimants Name	
Condition Suffered	
Date first unable to attend usual occupation	
Date the Claimant will/predicted return to work	
Total Disablement from usual occupation Commencement Date: To:	Yes / No
Partial Disablement from usual occupation Commencement Date:	Yes / No

To:	
Has the Claimant suffered previously from this condition or any similar condition? If so, please provide details.	
Signature and Qualification	
Date	
Name	
Address	

Details of Other Insurance

Is the Injured Person covered under any other health / personal accident insurance?	
If Yes, please provide the name, address and telephone number of the Insurance Company and/or Broker	

Out of Pocket expenses for Persons who are not in Employment

Eg Retired / Unemployed where they are unable to claim for the weekly benefit

*** The policy may reimburse any expenses incurred from bodily injury whilst volunteering for the WFA**

Please provide receipts for incurred expenses for Insurers review: Attached YES / NO

Amount:

Your Rights / Access to Medical Reports Act 1988

To enable us to consider your claim further we require a medical report from the Doctor you are consulting for this condition. To do this we require your consent, which you can indicate in the space below. Before doing so you should read the following statement that details your rights under the Access To Medical Reports Act 1988. You do not have to provide your consent to us being provided with a report but if you do you have the right to tell their doctor that you wish to see the report before it is sent to us. In this case the doctor cannot send it to us unless they have shown it to you or 21 days have passed without you having contacted your doctor about arranging to see the report. Even if you do not initially ask to see the report before it is sent to us, the doctor must let you see a copy of the report for up to six months after it has been supplied to us, if you ask to see it.

Once you have reviewed the medical report, your doctor cannot submit it to us until they have your consent to do so. You can write to your doctor asking them to amend any part of the medical report if you consider it to be incorrect. Where you and your doctor are not in agreement with the content and the doctor is not willing to change their report, you can attach a statement of your views that can be submitted with report.

In the event that the doctor believes that viewing some of the report would be detrimental to your physical or mental state. In this circumstance the doctor will notify you that you are viewing an edited version of the medical

report. If the whole report is being withheld the doctor cannot send the report to us unless you give your express consent

Before Aviva or their Agents can apply for a medical report from your doctor, we require your consent. Before you sign below you need to be aware that you have certain rights under the Access to Medical Reports Act 1988 as detailed above, in summary:

- You can withhold your consent
- You can ask to see the report before it is sent to us, and up to six months afterwards
- You can ask the doctor if they can amend any of the content of the report which you consider to be incorrect. If your doctor declines to amend you can attach your comments to the report
- Your doctor can withhold some/all of the report if they believe viewing it could be detrimental to your health

I have been informed of my statutory rights under the Access to Medical Reports Act 1988, and in connection with my insurance claim I hereby give consent to Aviva or their Agent

I wish to see the report before it is sent to the company*	
I do not wish to see the report before it is sent to the company*	
Signed	**Date**
Printed Name	

Settlement Details

Claims payments made by BACS transfer or other electronic banking system can be made and credited to your account more quickly than a cheque.

By entering your bank account details, you confirm that Aviva has your full authority to remit monies directly to that account by the BACS or other electronic banking system. You also accept that, providing payment remitted to the bank account designated by you, Aviva and their Agents shall have no further liability or responsibility in respect of such payment, and that it shall be your sole responsibility to make collection of any misdirected payment.

Name of Account Holder:	
Type of Current Account (e.g. Platinum / Gold / Premier):	
Name and Address of Bank / Building Society:	
Sort Code:	
Account Number:	

Please return to by email to: gpaclaims@aviva.com, alison.barnard@sports-insure.co.uk
* Email is quicker, safer and speeds payments up

Or if post is only option (retain copies in case of non-delivery)
Post to:

Aviva PA, 4th Floor, The Observatory, Chapel Walks, Manchester M2 4AL