



ROCHDALE ONLINE
ALLIANCE FOOTBALL LEAGUE

T. WINN
Insurance Officer
37 Moorland Avenue
Milnrow
Rochdale
Lancs. OL16 3DZ
Tel: (01706) 356077
Mobile 07729 335635
E-mail: Trevor.Winn@btinternet.com

Dear Secretary,

Insurance Claim Form

Please arrange for the form to be completed and then return it to me at the above address. I will then copy this and submit it to the Insurance Brokers on your behalf. Please also provide a witness statement and a copy of the team sheet for the game in which the player was injured.

Yours Faithfully

Trevor Winn



LRO INSURANCE CONSULTANTS

PERSONAL ACCIDENT CLAIM FORM

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 documentation is not immediately available
- Complete the form clearly and in BLOCK CAPITALS

Once complete you should return this form to your insurance broker.

INSURED DETAILS	
Policy Number:	808752010LIR-5003
Issuing Broker:	LRO Insurance Consultants
Insured (the Policyholder):	ROCHDALE ALLIANCE FOOTBALL LEAGUE
Address:	C/O 4 GLEN ROYD, INGS LANE ROCHDALE
	Postcode: OL12 7DY
Contact Name:	TREVOR WINN
Position:	INSURANCE OFFICER
Telephone Number:	01706 356077
Email:	trevor.winn@btinternet.com

INSURED PERSON (CLAIMANT) DETAILS	
Insured Person: (if different from above)	
Address: (if different from above)	
	Postcode:
Date Of Birth:	Occupation:
Telephone Number:	Email:
Insured Person's Appointed Representative:	TREVOR WINN
Address:	37 MOORLAND AVENUE, MILNROW ROCHDALE
	Postcode: OL16 3DZ
Telephone Number:	01706 356077
Email:	trevor.winn@btinternet.com

ACCIDENT & BODILY INJURY DETAILS

Date the 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:

or

3. The date on which you expect to return to your occupation:

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 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:

Telephone Number:

Thank you for your time and assistance in completing this form.

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 prevention 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 small fee) and to have any inaccuracies corrected.

DOCTOR'S 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

If YES, please give details including dates, treatment and consultations:
(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 to 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: _____ Qualifications: _____

Name (please print): _____ Date: _____

Please use validation stamp or complete in block capitals:

Name & Address:

Telephone Number:

Thank you for your time and assistance in completing this form.

ACCESS TO MEDICAL RECORD ACT 1988

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 Records 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 any 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.

Signed: _____

Date: _____

DECLARATION

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

Signed: _____

Date: _____

Name (please print): _____

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

- You have fully answered all relevant questions before your doctor completes his statement.
- You have enclosed all requested information and documentation.
- 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.