The National Game Insurance Scheme

Delivered by The FA's appointed broker, Bluefin Sport

Personal accident claim form

Guidance notes:

Please arrange to return the fully completed form either by:

Post: ACE European Group, PO Box 4511, Dunstable, LU6 9QA
or
Email: claims@acegroup.com.

The insurers (ACE) will contact the injured player directly with his unique claims reference number within 5 working days of receiving the claim form. **If an e-mail address is provided they will use this method to communicate with you whilst dealing with your claim.**

To ensure benefits are paid promptly, claimants will be given the option on the claim form to elect for their payment to be made by BACS, so please ensure this section of the claim form is completed.

We strongly recommend the player/claimant keeps copies of all paperwork and correspondence sent to ACE.

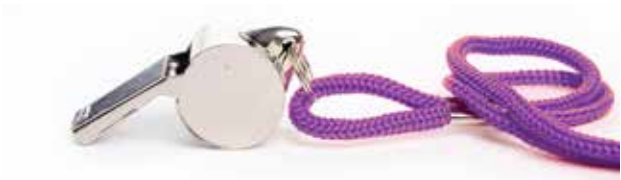
Checklist ✓

Useful notes:

You fully complete every question before your doctor completes his statement	☐
The bank account details of the payee has been completed on page 8	☐
You have signed and dated the patient access declaration on page 7	☐
The club secretary or a club official has signed the claim form on page 8	☐
You have signed the claim form on page 8	☐
You have enclosed all requested information/documentation	☐
Your attending doctor fully completes the statement on pages 5 & 6	☐

Require assistance?

If you have any questions, please call ACE Claims on 0345 841 0059



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Club details (This section is to be completed by you)

Full name of club: _____

Policy number UKBOPC/ _____

Contact address _____

_____ Postcode: _____

Contact name _____ Contact telephone _____

Email _____

Affiliated County FA_____ League _____

Claimant details:

Full name: _____

Date of Birth _____

Address _____

_____ Postcode: _____

Home telephone _____ Work telephone _____

Email _____

For security reasons please provide a password which will be required to access your claims information:

Password:_____

Employment details:

What is your occupation? _____

Please describe your duties:_____

_____

Please state average gross and net salary over previous 12 months from the date of the incident (please enclose copies of 13 weeks payslips prior to the event) or over the previous 36 months from the date of accident if self employed (please provide evidence of income by means of Inland Revenue Tax Assessment forms or audited accounts):

Gross: _____ Net: _____

Name and address of employer _____

_____

E-mail address of employer_____

Accident details:

Please give exact date and time when injured:

Date:_____ Time: _____

Please state fully:

Where the accident occurred: _____

_____

_____

_____

How the accident occured: _____

_____

_____

_____

The injuries sustained: _____

_____

_____

_____

Have you previously claimed under this or a similar policy?
Yes o No o

If 'Yes' please provide details _____

_____

_____

_____

Please give the name, address and policy number of any other insurance policy that may cover this injury

_____

_____

_____

_____

_____

_____

Hospital Statement: (Only complete this section if you are claiming a hospitalisation benefit)

Please note

This section must be fully completed by hospital medical staff or records - any fee for completion of this section is the responsibility of the claimant

Type of hospital/ward: _____

Name of Doctor or Consultant:_____

_____

Dates admitted and released: Admitted: _____ Released: _____

Was any period spent in intensive care? Yes o No o

If 'Yes' please provide the dates: From: _____ To: _____

Was the patient subsequently confined to their home on medical grounds? Yes o No o

If 'Yes' please provide the dates: From: _____ To: _____

If there is any additional information that you feel is relevant, please provide:_ _____

_____

_____

_____

Your signature _____ Date: _____

Qualifications: _____ Position: _____

Please use validation stamp or complete in BLOCK CAPITALS

Hospital name: _____

Address: _____

_____ Postcode: _____

Telephone: _____

Validation Stamp:

Doctors Statement:

Please note

This section must be fully completed by attending doctor.

Patients name (Mr, Mrs, Miss, Ms) _____

Date of Birth: _____ Height: _____ Weight: _____

Please give full details of injury: _____

_____

_____

_____

_____

_____

Final diagnoses: _____

_____

_____

_____

_____

_____

When did the patient first receive medical attention for this condition? _____

_____

Has the patient ever suffered with this or any similar condition before the present episode? Yes o No o

If 'Yes', please give details including dates and consultation: _____

_____

_____

_____

_____

Are you the patients usual Doctor? Yes o No o

If 'No', please give name and address of usual doctor: _____

_____

_____

_____

_____

(Continued overleaf)

Doctors Statement continued:

On what date did incapacity commence?: _____

Is the patient still incapacitated?: Yes o No o

If 'Yes', when will patient be able to return to work? _____

_____

_____

If 'No', when did incapacity cease? _____

_____

_____

_____

If there is any additional information that you feel is relevant, please provide _____

_____

_____

_____

Your signature: Date:

Qualifications:

Please use validation stamp or complete in BLOCK CAPITALS

Name: _____

Address: _____

_____

_____ Postcode: _____

Telephone: _____

Validation Stamp:

Access to Medical Reports Act 1988:

Before your attending doctor can give a medical report on this claim form which is a requirement of this claim, you must give your consent. Before giving your consent, you should be aware of your rights under the act which are summised as follows:

1. You may withhold your consent.
2. You may see the report before it is sent to us within 21 days from the date of this report.
3. You may ask to see the report for up to 6 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.

NB: 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

Having been made aware of my statutory rights under the Access to Medical Reports Act 1988 in connection with my claim:

1. I hereby consent to ACE seeking medical information from my doctor who at any time has attended me concerning conditions which may affect my physical or mental health.
2. Please tick one of the following options below:

   ☐ I DO wish to see the report before it is sent to ACE

   ☐ I DO NOT wish to see the report before it is sent to ACE

3. I authorise such doctor to disclose such information to ACE.
4. I agree a copy of this consent shall have the validity of the original.

Signed _____ Date _____

Payee Bank details:

Important

When the claim has been approved, you may have the payment credited direct to your bank account. This payment method is both speedier and safer than by cheque. If you would like to take advantage of this arrangement, then please complete the following;

Name of your Bank/Building Society:_____

Address including postcode:_____

_____ Postcode: _____

Bank Sort Code | | | | | | |

Account Number | | | | | | | | | | |

Account Name:_____

Data Protection:

The information that you and your medical representative have provided in the claim form and Doctor's Statement is 'sensitive data' as defined by the Data Protection Act 1988. Sensitive data includes any information about your physical and mental health. We require your consent before we can process this or any other such sensitive data that you may have already provided us with or may do so in the future.

In order to administer your claim, this information will be used by ACE. It may be held on computer and or in manual files for administration, and risk assessment purposes. We may disclose your personal data and sensitive data to, and may request information from other insurance companies for underwriting, claims handling and fraud prevention purposes.

By returning this form, you consent to our processing your sensitive personal data for the above purposes. You also consent to our transferring your information to countries which do not provide the same level of data protection as the UK, if necessary for the above purposes. If we do make such a transfer we will, if appropriate put a contract in place to ensure your information is protected.

Where you have provided information about another person, you confirm that they have appointed you to act for them, to consent to the processing of their personal data, including sensitive data, to the transfer of their information abroad and to receive on their behalf any data protection notices.

Declaration:

I declare that all the information given is to the best of my knowledge and belief, full true and correct.

Claimant signature: Date:

Club official signature: Date:

Postion in club:

Thank you for completing this form: Please return the completed claim form together with any enclosures to: ACE Group, claims Department, PO BOX 4511, Dunstable, LU6 9QA.

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