

Please Return Form To:-
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**FA Licensed Coaches Club
PERSONAL ACCIDENT CLAIM FORM**

This form to be completed on both sides and returned immediately

A) Claimant (Injured Person)

- 1. Name Date of Birth
- 2. Address
..... Tel No:
- 3. Usual Occupation
- 4. Presently Employed YES / NO

B) Date of Accident

C) Injury Sustained

D) State briefly how injury was caused, giving full details of activity being undertaken:-
.....
.....

F) Name & Address of any Witnesses

DATA PROTECTION ACT: All information you provide on this form is treated by us as confidential and except to the extent required by law, we shall only use such information for the purposes of processing your claim. Information you provide may be forwarded to your Insurer for these purposes.

Signature **Date**

PROOF OF COACHES CLUB MEMBERSHIP

You should either attach a copy of your current proof of membership, or forward to the FA Coaches Club for completion of details below as verification of your membership.

Name:(Person Confirming Membership)

Position :

- Is Claimant a current FA Coaches Club Member?** YES / NO
- Has the Member paid the appropriate insurance premium.** YES / NO
- Did the incident take place whilst participating in insured activity?** YES / NO

If any answers are stated as "No" please provide detail.

Signature **Date**

HOSPITALISATION CERTIFICATE FORM (To be completed if claiming Hospital Benefit)
(TO BE COMPLETED BY THE CLAIMANT'S HOSPITAL DOCTOR)

Name of Patient

Nature of Injury

I, the undersigned hereby confirm that as a sole result of the accident on (date).....the above patient was an
Inpatient at (name of hospital).....

From (date & time).....

To (discharge date & time).....

Signed..... **Qualification**.....

Date Signed.....

DENTAL CLAIMS (Emergency Treatment only)
(£50 Excess applies)

Nature of Injury sustained.....

Date of first dental appointment.....

PLEASE SUBMIT A FULLY DETAILED INVOICE FROM YOUR DENTIST GIVING PRECISE INFORMATION OF TREATMENT RECEIVED.

BROKEN BONES (ARM OR LEG)
(TO BE COMPLETED BY THE CLAIMANT'S HOSPITAL DOCTOR)

Nature of Injury

Name of Hospital

DOCTOR'S SIGNATURE

Qualifications

Date Signed

Claimant's Signature **Date**