



Warrington & District Football league - Benevolent Fund Personal Accident Claim Form

Please answer all sections fully (except section C if a separate medical certificate is submitted) return this form to the Benevolent Secretary within 15 days of the accident.

OFFICE USE Date Received..... Claim Number.....

1, Full Name of Club.....

2. Name & Address of Club Secretary.....

3..... Tel No

3a Name of Claimant.....

3b I.D. No On Club Roll.....

3c Weekly Amount of Claim £ 60/£30/£15/£5

4a Opposing Team..... Home or Away.....

4c Status of Match league/League Cup tie / County Cup Tie/ Authorised friendly

5 Name of Referee

6 Name & Address of opposing Club Secretary.....

.....Tel No.....

7 Date of Accident.....Time.....

8 Place.....

9 Details of Accident.....

.....

.....

10a Did the accident occur during a match ? Yes/No

10b If "NO" state details below at 11.

10c was the injury treated during the match Yes/No

10d was the injury recorded on the Team sheet? Yes/ No

10e If Not state the reason why.....

.....

11 Any other relevant details.....

.....

12 Signed: (Secretary) Date.....



Warrington & District Football league - Benevolent Fund Personal Accident Claim Form

Section (B) to be completed by the claimant – Also note claimant should send bank details to the League Treasurer for Bacs Payment.

1 Full Name of Claimant

2a Address Tel No.....

2b Occupation.....

2c Name & Address of Employer

3a Nature of injury sustained.....

3b Probable date of return to work

4 Name & Address of Doctor or Hospital Treating injury.....

.....

5a Date of commencement of incapacity

5b Date First Attended by Medical Authority

6 Do you play for any other club ? Yes / No

6a Name of Club Name of the League

6b . Name & Address of Club Secretary.....

.....Tel No

7. I certify that i am completely incapacitated from following my occupational by reason of this injury

Signed(Claimant) Date.....

Part (C) MEDIACL CERTIFICATE (SEE NOTE AT HEADING)

(THIS FORM AND OTHER CERTIFICATION TO BE PROVIDED AT CLAIMANTS EXPENSE)

I certify that A) Mr.....

Is suffering from.....

Caused to the best of my knowledge by.....

Which is the sole cause of his present incapacity ,

I declare that to the best of my knowledge at the time of the present injury the patient was not suffering from any previous physical condition or weakness likely to have been the cause of or contributed to the present injury.

Date of first attendance to meby hospital casualty.....

Anticipated duration of patients total incapacity from workWeeks

Signed(Qualifications).....