

# Garda Representative Association

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<b>Official Use Only</b>
File Ref: _____
Date Rec'd _____
Total Payment: _____

## Illness/Injury Claim Form

This form must be completed **in full** and a medical certificate furnished within ten weeks of the commencement of the illness/injury and at monthly intervals thereafter without expense to the Association. All further evidence required to be supplied at member's own expense. The issue of this form is in no way an admission to liability.

### PARTICULARS OF CLAIM:

1. Name: \_\_\_\_\_ 2. Registered No. \_\_\_\_\_
3. Station: \_\_\_\_\_
4. Home Address: \_\_\_\_\_
5. Nature of Illness/Injury: \_\_\_\_\_
6. Indicate if the illness/injury is related to the following by ticking the appropriate box:-  
Alcoholism: Yes:  No:  Pregnancy: Yes:  No:
7. Was the injury sustained on duty? \_\_\_\_\_
8. Was the injury sustained while playing sports? \_\_\_\_\_
9. Is there a claim pending against a third party or the State? \_\_\_\_\_
10. Are you covered by any other insurance? \_\_\_\_\_
11. If yes, give particulars: \_\_\_\_\_
12. Are you in receipt of other benefits from the GRA? \_\_\_\_\_
13. If yes, give particulars? \_\_\_\_\_
14. Date on which absence commenced: \_\_\_\_\_
15. Period of non effectiveness – From: \_\_\_\_\_ To: \_\_\_\_\_

### GENERAL:

11. Doctor consulted initially: (i) Name: \_\_\_\_\_  
(ii) Address: \_\_\_\_\_
12. Doctor treating you: (i) Name: \_\_\_\_\_  
(ii) Address: \_\_\_\_\_
13. Have you previously made a claim in connection with this illness/injury from:-  
(i) Garda Representative Association \_\_\_\_\_  
(ii) Insurance Company \_\_\_\_\_

If yes, give particulars with approximate date and period of incapacity: \_\_\_\_\_

I hereby authorise my Doctor to release any information required in the course of my examination or treatment.

I hereby declare: (a) I am a member of the Garda Representative Association.

(b) I acknowledge the conditions of the Scheme and certify that the particulars supplied are correct to be best of my knowledge and belief.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Phone No: \_\_\_\_\_ Email \_\_\_\_\_

# MEDICAL CERTIFICATE

In order to process a claim it is essential that the Medical Attendant of the member should complete this form. This form must be completed free of expense to the Association.

1. Name of Member: \_\_\_\_\_
2. Home Address: \_\_\_\_\_
3. When did you first see the member in connection with this incapacity? \_\_\_\_\_
4. Is the member currently attending? \_\_\_\_\_ If yes, when last seen? \_\_\_\_\_
5. (a) Nature of illness/injury and present condition: \_\_\_\_\_  
(b) Is the illness related to (i) Alcoholism \_\_\_\_\_ (ii) Pregnancy: \_\_\_\_\_  
(c) Treatment: \_\_\_\_\_
6. Date illness/injury commenced: \_\_\_\_\_
7. In your opinion is the member totally or partially disabled from performing duty? \_\_\_\_\_  
\_\_\_\_\_
8. Duration of period certified unfit to perform duty:-  
From: \_\_\_\_\_ To: \_\_\_\_\_
9. When do you think the member will be fit to return to duty? \_\_\_\_\_  
\_\_\_\_\_
10. Are you aware of anything in the medical history of the member likely to be connected with the present illness/injury? \_\_\_\_\_  
\_\_\_\_\_

## REMARKS:

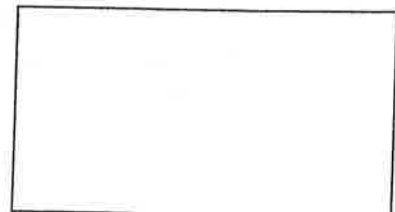
Please state any additional information which may be of assistance in determining the duration of the non-effectiveness? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I certify that I have satisfied myself by personal examination that all the foregoing statements are correct.

Signature: \_\_\_\_\_

(Doctor's stamp required)

Address: \_\_\_\_\_  
\_\_\_\_\_



Date: \_\_\_\_\_