Garda Representative Association

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Official Use Only
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: _____