ELLINBANK & DISTRICT FOOTBALL LEAGUE INCORPORATED

PLAYERS' ACCIDENT FUND

E.D.F.L. Claim No.....

1 LOSS OF INCOME CLAIM FORM

Player's Full Name: .....
Address: .....
.....Postcode:.....
Phone Number: .....(H).....(W). Date of Birth:...../...../.....
Employed by: .....
Address: .....
Football Club: .....Grade: 1st 2nd 3rd XVIII
Nature of Injury: .....Date of Injury:..../..../....
Certificate from Doctor: Doctor.....attached
Dependants: Spouse: ..... Children: ..... Number of Children: .....

I declare the amount of income loss by me during the above period amounted to $.....
calculated as follows:
..... weeks .....days lost from work at normal wage of $.....per week

Signature of Player :..... Date: / / .

2 CERTIFICATE BY CLUB SECRETARY

I certify that player .....sustained a
.....whilst playing at
..... on / / . during practice/match
authorised by this Club.

....
Name of Club Secretary or claims Officer Signature
Contact Phone Number:.....

3 CERTIFICATE BY EMPLOYER / SELF EMPLOYED

It is certified that:.....(Employee) / (Self Employed)
is employed by:.....(Employer)/(Business Name)
of (Employers Address):.....
Phone Number:.....
He was absent from work WITHOUT PAY for the period:..... to .....incl.
His loss of wages during this period was ..... days amounting to $..... at his normal wage of $ ..... per week.

....
Contact Name Signature and Position

Please complete details on back of this claim form.