Federal Insurance Company Police and Fire Accident Program
NOTICE OF CLAIM

A claim is being filed for: ☐ Medical Benefits ☐ Disability Benefits ☐ Medical and Disability Benefits

Forward Questions/Claims to:

Cabot Risk Strategies LLC
15 Cabot Road, Woburn, MA 01801-1003
Tel. Number 800-222-5963 Fax Number 781-376-9907

Claim Instructions: The Policyholder should: Complete and sign Sections 1, 3 and 5. The Claimant should: Complete and sign Sections 2, 3 and 4.

Section 1 – Policyholder Information – To be completed by commanding officer

Policyholder Name	Policyholder Number	
Policyholder Address	Commanding Officer Phone Number	
Claimant (Injured Party) Name	Claimant Date of Birth	Claimant Social Security Number
Claimant Insured Person Status ☐ On-Call Volunteer ☐ Junior Officers ☐ Auxiliary ☐ Career Police ☐ Career Fire Fighter		
Claimant Address (Street, City, State and Zip Code)	Claimant Phone Number	
Date of Accident _____ (mm/dd/yyyy)	Time of Accident _____ ☐ AM ☐ PM hh:mm	Place of Accident
Complete description of Accident		
Indicate injured body part(s)		
Nature of sickness (if applicable)	Date sickness first commenced	

Note – Please also include a copy of the Incident Report, if available.

Policyholder Certification Signature Required:
I hereby certify the claimant is a member of the group insured under the above Policy and the injury/sickness was sustained under adequate supervision while participating in an official Covered Activity.

Title of Commanding Officer	Signature of Commanding Officer	Date

Section 2 – Claimant Information – To be completed by claimant

If filing a claim for Medical Benefits: Submit itemized medical bills to address referenced above and sign the Claimant Certification statement listed below.

Claimant Certification Signature Required:
I hereby certify the above information to be true and accurate to the best of my knowledge.

Signature of Claimant	Date

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Section 2 – Claimant Information (continued)

[If filing a claim for Disability Benefits: Fully complete all items in this section and submit to address referenced on page 1.]

Primary Occupation	Primary Occupation Work Hours	Name of Primary Occupation Employer
Address of Primary Occupation Employer	Contact Phone Number	Contact Fax Number
Contact Name for Primary Occupation Employer	Exact duties unable to perform – Primary occupation	
Date last worked Primary Occupation Employer	Date returned to work – Primary Occupation Employer ☐ Full Duty ☐ Light Duty	
Verification of Earnings *(Submit Primary Occupation pay stubs for the last 3 months. If self-employed, send copy of your prior year's tax return)*		
Attending Physician's Name	Attending Physician's Address	
Attending Physician's Phone Number	Attending Physician's Fax Number	
Do you have disability (loss of wages) coverage through? (Check all that apply) ☐ Regular Occupation Policy ☐ Workers' Compensation ☐ Other		
Claimant Certification Signature Required: I hereby certify the above information to be true and accurate to the best of my knowledge. Signature of Claimant / Date		

Section 3 – Fraud Warning Statement – To be signed by policyholder and claimant

It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

I hereby certify the foregoing statements made by me on this form to be true to the best of my knowledge. I am aware that if any of the foregoing statements made by me are willfully false, I may be subject to penalties, which may include criminal prosecution.

Signature of Policyholder (Commanding Officer) — Date

Signature of Claimant — Date

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Section 4 – Medical Records Release

Forward Documentation to:

Cabot Risk Strategies LLC
15 Cabot Road
Woburn, MA 01801-1003
Tel. Number 800-222-5963
Fax Number 781-376-9907

Date of Injury _____
(mm/dd/yyyy)

Nature of Injury

I hereby authorize any hospital, physician or other person who has attended me to furnish to Cabot Risk Strategies LLC and Chubb Group of Insurance Companies all information with respect to this illness or injury and the resulting hospital or medical records, consultations, treatments or prescriptions. A copy of this authorization shall be considered as effective and valid as the original.

_____
Name (Print)

_____ _____
Signature Date

Section 5 – Wage and Salary Verification

Forward Documentation to:

Cabot Risk Strategies LLC
15 Cabot Road
Woburn, MA 01801-1003
Tel. Number 800-222-5963
Fax Number 781-376-9907

Date	Our Policyholder	Date of Injury	Claim Number

EMPLOYER'S NAME AND ADDRESS	EMPLOYEE'S NAME AND ADDRESS
	Social Security No.:

OCCUPATION:

DATES OF EMPLOYMENT: From _____ through _____

Gross Earnings during 52-week period ***PRIOR*** to Accident: $ _____

Wage or salary as of date of Accident:

a) $ _____ ☐ Per Week ☐ Per Month

b) Usual number of days worked per week: _____

Dates Absent Following Accident:

a) Date Disability began: _____

b) Date returned to work _____

Was Employee paid during this absence: ☐ YES ☐ NO If YES, amount paid: $ _____

Is Employee entitled to benefits under a wage or salary continuation plan? ☐ YES ☐ NO

a) If YES, amount paid or available: $ _____ ☐ PER WEEK ☐ PER MONTH

b) If YES, Are cash or traditional retirement credits reduced under your plan by amount of benefits paid?

Is Employee eligible for any individual/group health insurance/HMO/other benefits? ☐ YES ☐ NO

Date: _____ Print Name & Title: _____

Telephone No.: _____

_____
Signature

Thank you for your cooperation.

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