



**Police and Fire Fighter Accident Program  
NOTICE OF CLAIM FORM**

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 I, III and V.  
The Claimant should: Complete and sign Sections II, III and IV.

**Section I – 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 <input type="checkbox"/> On-Call Volunteer <input type="checkbox"/> Junior Officers <input type="checkbox"/> Auxiliary <input type="checkbox"/> Career Police <input type="checkbox"/> Career Fire Fighter			
Claimant Address (Street, City, State and Zip Code)		Claimant Phone Number	
Date of Accident _____ (mm/dd/yyyy)	Time of Accident _____ hh:mm	<input type="checkbox"/> AM <input type="checkbox"/> PM	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 II – 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



**Section II – (Continued) Claimant Information**

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

Normal Occupation	Normal Occupation Work Hours	Name of Normal Occupation Employer	
Address of Normal Occupation Employer		Contact Phone Number	Contact Fax Number
Contact Name for Normal Occupation Employer	Exact duties unable to perform – Normal occupation		
Date last worked Normal Occupation Employer	Date returned to work – Normal Occupation Employer _____ <input type="checkbox"/> Full Duty <input type="checkbox"/> Light Duty		
Verification of Earnings (Submit Normal 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 <u>disability</u> (loss of wages) coverage through? (Check all that apply)			
<input type="checkbox"/> Regular Occupation Policy <input type="checkbox"/> Workers' Compensation <input type="checkbox"/> Other _____			
<i>Claimant Certification Signature Required:</i> I hereby certify the above information to be true and accurate to the best of my knowledge.			
_____ Signature of Claimant		_____ Date	

**Section III – Fraud Warning Statement – To be signed by Policyholder and Claimant (Based on State of residence)**

For residents of Alaska, Arizona, Arkansas, Colorado, Connecticut, Delaware, D.C., Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Washington, West Virginia and Wisconsin: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

For residents of Alabama, Hawaii, Oregon, Vermont, Virginia, and Wyoming: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material is subject to a denial and/or reduction insurance benefits and may be subject to any civil penalties available.

For residents of California, California law requires the following: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

For residents of New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

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 on this form 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



**Section IV – Medical Records Release**

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

MEDICAL RECORDS RELEASE

DATE OF INJURY \_\_\_\_\_

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