Chubb 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: Town of Greenfield
Policyholder Address: 14 Court Square, Greenfield, MA 01301
Policyholder Number: GRE00417-03-13
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
Place of Accident: __________________ hh:mm

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: __________________

(12/11)
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.

<table>
<thead>
<tr>
<th>Normal Occupation</th>
<th>Normal Occupation Work Hours</th>
<th>Name of Normal Occupation Employer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address of Normal Occupation Employer</td>
<td>Contact Phone Number</td>
<td>Contact Fax Number</td>
</tr>
<tr>
<td>Contact Name for Normal Occupation Employer</td>
<td>Exact duties unable to perform – Normal occupation</td>
<td></td>
</tr>
<tr>
<td>Date last worked Normal Occupation Employer</td>
<td>Date returned to work – Normal Occupation Employer</td>
<td></td>
</tr>
<tr>
<td>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)</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Attending Physician’s Name</td>
<td>Attending Physician’s Address</td>
<td></td>
</tr>
<tr>
<td>Attending Physician’s Phone Number</td>
<td>Attending Physician’s Fax Number</td>
<td></td>
</tr>
</tbody>
</table>

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 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

(12/11)
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

(12/11)