Temporary Total Disability & Accidental Injury Claim

In order to promptly process your request, please complete all fields on the enclosed claim form and forward the following documents to us as soon as available:

- Completed claim form (enclosed);
- Attending Physician Statement (enclosed);
- Medical records authorization release form (enclosed);
- Medical records related to the Accidental Injury;
- Medical records that show continuous care since the date of loss (accident)
- Most recent pay stubs (most show gross for year to date for the last 6 months) or Tax Return from prior year
- List of all benefits already paid;
- Police or incident report, if applicable.

Send the completed and signed claim form and all required document to

California Reserve Peace Officers Association
Membership and Finance Office
PO Box 1238
Pacifica, CA 94044

Or

Attach a PDF copy and email to

Carrie Lujan
carrie@crpoa.org

Please retain a copy for your records.

YOU WILL BE CONTACTED BY A CLAIM ADJUSTER
IF ADDITIONAL INFORMATION OR DOCUMENTATION IS REQUIRED.

IF YOU HAVE ANY CLAIM RELATED QUESTIONS PLEASE CALL CARRIE AT (650) 290-6892

Accidental Injury Claim

Claimant's Statement

(Please print – Attach separate sheet if additional space required)

INSURED INFORMATION

Insured's Name_____ **Date of Birth** ___/____/____ **Marital Status**_____ ____

Insured's Address _____ **Phone No. (H)**_____
_____ **Phone No. (W)**_____
Phone No. (C)_____

Name and address of employer _____ **Email Address**_____

Policy Number (Required)_____ **Insured's Occupation** _____

Did the insured have any other insurance ? _____**If yes, please list all companies, type of insurance, policy numbers and insurance amounts:**_____

CLAIM INFORMATION

Date of accident _____/_____/_____ **Time and place accident occurred**_____

Please describe in detail the circumstances of accident (attach separate sheet if needed): _____

_____

Was the accident related to the Insured's occupation? _____ **If so, how?** _____

Please describe the nature of Insured's injuries:_____

Please list the names and addresses of all treating physicians and hospitals:_____

_____

_____

Did police or other authorities investigate the accident? ____ If yes, please provide name, address and telephone number of all investigating officers and agencies: _____

CLAIMANT INFORMATION (If different than "Insured Information" above)

Claimant's Name_____ **Age**_____ **Relationship to Insured**_____

Claimant's Address_____ **Phone No. (H)** _____
_____ **Phone No. (W)**_____

Phone No. (C)_____
In what capacity are you making this claim? _____**Email Address**_____

AUTHORIZATION

I authorize any insurance company, physician, hospital or other healthcare provider, or any other organization, institution or person that may have records, documents or knowledge regarding the insured to release any information requested regarding this claim and the loss reported. I understand this information will be used by the Chubb Group of Insurance Companies, Crawford & Company, or its authorized representatives, for the purpose of evaluating and determining coverage for this claim. I know I have a right to receive a copy of this authorization upon request and agree that a photographic or facsimile copy of this authorization is as valid as the original. I agree that this authorization shall be valid for the duration of this claim.

I understand that any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete or misleading information may be subject to prosecution for insurance fraud.

SIGNED (Claimant or authorized person) _____ **DATE** ____/____/____

Claimant's Statement

(Please print – Attach separate sheet if additional space required)

INSURED INFORMATION

Insured's Name_____ Claim#: _____

Soc. Sec. No. _____-_____-_____

Date of Birth ____/____/____ (MM/DD/YY) Marital Status _____

Insured's Address _____

Phone No. (H)_____ Phone No. (W)_____

Phone No. (C)_____ Policy Number (Required) _____

Insured's Email Address (if applicable): _____

Are you eligible for or enrolled in Medicare? **YES / NO** Are you enrolled in Medicaid? **YES / NO**

CLAIM INFORMATION

Date of accident ____/____/____ (MM/DD/YY) Time of Accident: _____ am/ pm

Place accident occurred: _____

Please describe in detail the circumstances of accident (attach separate sheet if needed):

_____

_____

Was the accident related to the Insured's occupation? **YES / NO**

If so, how? _____

Please describe the nature of Insured's injuries: _____

_____

_____

Did police or other authorities investigate the accident? **YES / NO**

If yes, please provide name, address and telephone number of all investigating officers and agencies:

Name	Street Address	City	State	Zip	Phone

Please list the names and addresses of all treating/consulting physicians or other healthcare providers:

Name	Street Address	City	State	Zip	Phone

If hospitalized, please provide name and address of hospital(s) where treatment was received:

_____

_____

Do you have any other insurance that may provide coverage for this accident or loss? **YES / NO**

If yes, please identify name, address, and policy number of all other insurance:

_____

_____

If you do not have any other insurance that would cover this loss please complete the "Certification of No Other Insurance" portion of this form.

AUTHORIZATION

I authorize any insurance company, physician, hospital or other healthcare provider, or any other organization, institution or person that may have records, documents or knowledge regarding the insured to release any information requested regarding this claim and the loss reported. I understand this information will be used Broadspire Services, Inc., a subsidiary of Crawford & Company, or its authorized representatives, for the purpose of evaluating and determining coverage for this claim. I know I have a right to receive a copy of this authorization upon request and agree that a photographic or facsimile copy of this authorization is as valid as the original. I agree that this authorization shall be valid for the duration of this claim.

I understand that any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete or misleading information may be subject to prosecution for insurance fraud.

SIGNED (Claimant or authorized person) _____

DATE ____/____/____ (MM/DD/YY)

I authorize payment of medical benefits directly to the provider(s) for services rendered in connection with this claim.

Signed (Insured or authorized person)_____

DATE ____/____/____ (MM/DD/YY)

CERTIFICATION OF NO OTHER INSURANCE

I, _____hereby certify that I have no other accident, health, Medicare, Medicaid or any other insurance covering this loss.

Signed (Insured or authorized person) _____

DATE ____/____/____ (MM/DD/YY)

IMPORTANT NOTICE

Notice to Alaska Claimants: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Notice to Arizona Claimants: For your protection, Arizona law requires the following statement to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Notice to Arkansas Claimants: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Notice to California Claimants: For your protection, California law requires the following to appear on this form: Any person who knowingly presents a 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.

Notice to Colorado Claimants: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties many include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Notice to Delaware Claimants: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement or claim containing any false, incomplete, or misleading information is guilty of a felony.

Notice to District of Columbia Claimants: WARNING: 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.

Notice to Florida Claimants: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information, is guilty of a felony of the third degree.

Notice to Idaho Claimants: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete, or misleading information, is guilty of a felony.

Notice to Indiana Claimants: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Notice to Kentucky Claimants: Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

Notice to Maine Claimants: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Notice to Maryland Claimants: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Notice to Minnesota Claimants: A person who submits an application or files a claim with intent to defraud or helps commits a fraud against an insurer is guilty of a crime.

Notice to New Hampshire Claimants: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

Notice to New Jersey Claimants: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Notice to New Mexico Claimants: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

Notice to New York Claimants: 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.

Notice to Ohio Claimants: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Notice to Oklahoma Claimants: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Notice to Oregon Claimants: Any person who, knowingly and with intent to defraud an insurance company or other person, submits an application or files a claim for insurance that contains any materially false information relating to an insurance company's acceptance of risk, or conceals for the purpose of misleading, information concerning any fact material to an insurance company's acceptance of risk, may be guilty of a fraudulent act, which is a crime.

Notice to Pennsylvania Claimants: 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.

Notice to Rhode Island Claimants: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Notice to Virginia Claimants: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Notice to Claimants in all other states: Any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete or misleading information may be subject to prosecution for insurance fraud.

Attending Physician's Statement

(Please print – Attach separate sheet if additional space required)

PATIENT INFORMATION

Patient's Name_____ Soc. Sec. No. _____-_____-_____

Date of Birth ____/____/____ (MM/DD/YY) Marital Status _____

Patient's Address_____

Phone No. (H)_____ Phone No. (W)_____

Insured's Name: _____ Patient's relationship to Insured: _____

Insured's Email Address: _____

Policy Number (Required) _____

Are you related by blood or marriage to the Insured? **YES / NO**

CLAIM INFORMATION

Are you the patient's primary treating physician? **YES / NO**

If not, please provide the name and address of primary treating physician:

_____

Date of accident: ____/ ____/____ (MM/DD/YY)

Date of first treatment: ____/____/____ (MM/DD/YY)

Please describe in detail the nature of the Insured's injuries, including all applicable ICD-9-CM codes:

_____

_____

_____

Was the accident related to the Insured's occupation? **YES / NO**

If so, how? _____

Was the patient hospitalized? **YES / NO**

If yes, please list the names and addresses of all hospitals and all admission/discharge dates:

Hospital Name	Address	Admission Date MM/DD/YYYY	Discharge Date MM/DD/YYYY

Did the patient have any prior injuries that contributed to the patient's present condition? **YES / NO**

If yes, please describe:

_____

_____

_____

Were any surgical procedures performed? **YES / NO**
If yes, please list all procedures, including applicable CPT codes and dates performed:

_____

_____

_____

What are the patient's current subjective symptoms?

_____

_____

_____

What are the objective findings? (please include results of current x-rays, lab tests, etc.)?

_____

_____

Dates of Total Disability:		Dates of Partial Disability:	
From: (MM/DD/YYYY)	Through: (MM/DD/YYYY)	From: (MM/DD/YYYY)	Through: (MM/DD/YYYY)
Date Insured was able to return to work: (MM/DD/YYYY)			

Was the patient seen by any other physician? **YES / NO**

If yes, please list the names and addresses of all other physicians:

_____

_____

_____

_____

_____

ATTENDING PHYSICIAN INFORMATION

Name of Attending Physician: _____

Phone No. (_____)_____

Address: _____

_____

_____

Specialty: _____

I understand that any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete or misleading information may be subject to prosecution for insurance fraud.

SIGNED (Attending Physician) _____

DATE ____/____/____ (MM/DD/YY)

HIPAA Compliant Authorization To Release Confidential Medical Information

Records and information obtained will be disclosed to the third party administrator, Broadspire Services.

The purpose of this disclosure is to evaluate my application for insurance or claim benefits. I hereby authorize for you to release any and all records and information within your possession, custody or control regarding me pursuant to this Authorization. Any and all medical and non-medical records and information regarding me are to be released, including, but not limited to, financial, employment, police, complete driving and motor vehicle related records, as well as those relating to past and present illnesses, diagnosis, testing, treatments, and prognosis related to my physical and mental conditions. Such records and information to be released may include, but not be limited to, the following: alcohol abuse treatment and counseling, drug abuse treatment and counseling, psychiatric treatment, pharmacy prescriptions, Acquired Immune Deficiency Syndrome (AIDS), HIV testing and treatment, STD testing and treatment, genetic testing, Sickle Cell testing and treatment, lab data and EKG's.

I, the undersigned, hereby authorize any and all medical practitioners, physicians, pharmacists, hospitals, clinics, nurses, records custodians, ("My Providers"), employers, financial custodians, law enforcement agencies, governmental agencies, medical examiners/coroners, insurance companies, MIB, Inc. or anyone else located at:

Facility Name: _____ Telephone # _____

Address: _____ City _____ State _____ Zip _____

To release any and all records and information regarding:
Patient's Name: _____
First Middle Last

Other Names Used: _____

Date of Birth (MM/DD/YYYY): _____ Social Security Number: _____-_____-_____

Specifics to be released: _____

To be released to and exchanged between the claim administrator first named above, and/or the following companies:

The Records Company, Coastal Records, Covent Bridge

Other: _____

and their agents, contractors, employees, representatives, affiliates, and assigns as necessary to fulfill the purpose of this disclosure.

I understand that when my medical records are disclosed pursuant to this Authorization, my medical records and the information contained in those records may become subject to further disclosure by the insurance company. For example, the insurance company may be required to provide it to an insurance regulatory or other government agency. In this case, the information may no longer be protected by the rules governing this Authorization. This Authorization will remain in effect a maximum of six (6) months from my date of signature below. I understand I may revoke this Authorization at any time by requesting such of ICS| Merrill in writing at its address stated above, unless action has already been taken in reliance upon it, or during a contestability period under applicable law. A photocopy of this Authorization will be treated in the same manner as the original.

I understand that if I refuse to sign this authorization to release my complete medical records, my insurance company may not be able to process my application for coverage, or if coverage has been issued, may not be able to process any benefit payments. I further understand that My Providers cannot condition treatment, payment, or eligibility for benefits on whether I sign this Authorization.

Signature of patient/guardian/personal representative:
_____ **Date:** _____

Legal relationship to applicant: _____
(Only if signed above by guardian or personal representative)

Witness signature: _____ **Witness Required**
(Only if required) **(only if marked)**

Notary signature: _____ **Notary Required**
(Only if required) **(only if marked)**