

**POLICEMEN'S/FIREMEN'S ACCIDENT CLAIM NOTICE**  
**PLEASE COMPLETE ALL QUESTIONS BELOW**

Cabot Risk Strategies LLC  
 12 Gill Street, Suite 1600  
 Woburn, MA 01801  
 Phone: (800) 222-5963 Fax: (781) 376-9907

POLICY NUMBER <b>9906-8778</b>	POLICY PERIOD	NAME OF AGENT Cabot Risk Strategies LLC
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NAME AND ADDRESS OF POLICY HOLDER:  
**Town of Foxborough 40 South St Foxborough Ma 02035**

NAME AND ADDRESS OF INJURED INSURED:	D.O.B.	S.S.N.
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DATE OF INJURY TIME [ ]PM [ ]AM	SPECIFIED DUTIES AT TIME OF ACCIDENT:
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LOCATION OF ACCIDENT:

WHAT WERE YOUR ACTIVITIES AT THE TIME OF YOUR INJURY:

TOTAL DISABILITY [ ]NO [ ]YES FROM TO	PARTIAL DISABILITY [ ]NO [ ]YES FROM TO	DATE RETURNED TO FULL DUTY
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OTHER OCCUPATION(if not full time) PLEASE COMPLETE	DUTIES UNABLE TO PERFORM
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NAME AND ADDRESS OF ATTENDING PHYSICIAN:

I hereby authorize any Insurance Company, Organization, Employer, Hospital, Physician, Surgeon or Pharmacy to release any information requested by Hartford Insurance Group or its representatives. A photostatic copy of this authorization shall be considered as effective and valid as the original. This release is valid only as it pertains to the above listed accident. No other use or dissemination is authorized.

Dated: \_\_\_\_\_, 200\_\_\_\_ Signature of Insured: \_\_\_\_\_

**To Be Completed by CHIEF OF DEPARTMENT**

I hereby certify that the above injuries were sustained in the performance of Police of Fire Department Duties, as reported by officer or firefighter.

Name or Organization: \_\_\_\_\_ Signed: \_\_\_\_\_  
 Policy Number: \_\_\_\_\_ Date: \_\_\_\_\_ Titled: \_\_\_\_\_

**ATTACHED HERETO ARE BILLS FOR HOSPITAL, NURSE, MEDICAL OR SURGICAL EXPENSE CREATED ON**

**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 years 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"/> Worker's 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

Cabot Risk Strategies LLC  
12 Gill Street-Suite 1600  
Woburn, MA 01801  
Phone: (800) 222-5963  
Fax: (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 all information with respect to this illness or injury and the resulting hospital or medical records, consultations, treatments or prescriptions. A photostatic copy of this authorization shall be considered as effective and valid as the original.

\_\_\_\_\_  
NAME (PRINT)

\_\_\_\_\_  
(SIGNATURE)

\_\_\_\_\_  
(DATE)