HALIFAX FIRE DEPARTMENT R&R ARTICLE 13	INJURIES ON DUTY
PAGE 1 OF 2	ISSUED: SEPTEMBER 25, 2009 REVISED: January 10, 2018 Jason Viveiros, Fire Chief

PURPOSE

The purpose of this policy is to provide a systematic process for the reporting and proper documentation of injuries sustained while on duty.

POLICY

A. Treatment

1. Any employee who while working, becomes ill or injured because of his/her duties and who requires immediate medical care shall be treated at the closest appropriate medical facility.

2. The initial treating physician or his/her designee will complete an occupational health report related to the injury.

3. A copy of the initial occupational health report will be forwarded to the Fire Chief by the injured employee or the treating physician as soon as practicable.

B. Reporting

Employee

1. Any member of the Halifax Fire Department that becomes injured while in the performance of their duties, no matter how minor, shall notify Fire Chief or the Officer in Charge immediately.

2. Any member of the Halifax Fire Department that is aware of an occupational related illness shall notify the Fire Chief within 24 hours.

3. The member shall, as soon as they become injured, fill out all required injury reports even if the member is not seeking medical treatment.

4. No member shall feign any illness or injury, or make false statements to the same effect.

Supervisor

1. Assure the Injured Employee receives medical attention if applicable.
2. Notify the Fire Chief of all injuries as soon as practical.
3. Provide the Fire Chief with a written report that details the circumstances which gave rise to the injury or illness within 24 hours.
4. Complete the firefighter injury report section of the MFIRS if a member is injured on a call.

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	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 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.]

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 _____ ☐ Full Duty ☐ 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 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

Section V – Wage and Salary Verification

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

WAGE AND SALARY VERIFICATION

Date	Our Policyholder	Date of Injury	Claim Number

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

Thank you for your cooperation.

1.	OCCUPATION:
2.	DATES OF EMPLOYMENT: From _____ through _____
3.	Gross Earnings during 52-week period ***PRIOR*** to Accident: $ _____
4.	Wage or salary as of date of Accident: a) $ _____ ☐ Per Week ☐ Per Month b) Usual number of days worked per week: _____
5.	Dates Absent Following Accident: a) Date Disability began: _____ b) Date returned to work _____
6.	Was Employee paid during this absence: ☐ YES ☐ NO If YES, amount paid: $ _____
7.	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?
8.	Is Employee eligible for any individual/group health insurance/HMO/other benefits? ☐ YES ☐ NO
	Date: _____ Print Name & Title: _____ Telephone No.: _____ _____ Signature

(12/11)