

Town of North Attleborough Police and Firefighters 111F Injured on Duty FLOWCHART

Forms **must** be completed and signed by Chief/Preparer and sent to Human Resources within **24 hours** of any accident/injury/incident sustained while on duty. Every member is required to report and document any accident/injury/incident thought to be caused as the result of a work-related activity or during an authorized department activity, the following procedures shall be followed:

Employee's Role

- **If an on the job accident/injury/incident sustained**, the Employee should seek immediate medical attention if applicable.
- If accident/injury/incident requires medical treatment, be advised that the employer has arranged for such attention at Sturdy Memorial Hospital. **Employees should state that their injury is work related and should direct all medical bills to the Town of North Attleboro Human Resources Dept., Woodcock Admin. Bldg., 6 Morse Street, North Attleboro, MA 02760. DO NOT USE YOUR PERSONAL INSURANCE!**
- Employee informs the Chief or designee of accident/injury/incident and **together** the following forms should be completed:
 - 1 – **Incident Report** - completed and signed by employee and/or Chief/Preparer
 - 2 – **Application For Injured – On – Duty Status** – completed and signed by employee and/or Chief/Preparer
 - 3 – **Supervisor's Incident/Accident Investigation Report** – completed and signed by Chief/Preparer
 - 4 – **Medical Release Authorization** - completed and signed by employee
 - 5 – **Refusal of Medical Treatment or Observation** - completed and signed by employee and Witness
 - 6 – **Unprotected Exposure Form** – completed and signed by employee if applicable
 - 7 – **If a prescription is needed, see the attached "Occupational Injury Temporary Prescription ID Card.**
- All further medical treatment and/or time away from work should be communicated with the Chief and Human Resources.
- Employees can contact the HR & Benefits Coordinator in Human Resources @ 508- 643-2175, ext. 401 regarding claims status.

Department Role

- Executive Assistant notifies Human Resources and Cc: Treasurer's Department that employee is going to be out on I.O.D. (Beginning date of IOD and end date of IOD (once known).
- When the Executive Assistant/Chief is made aware of an accident/injury/incident they should immediately contact Human Resources via email or phone.
- Executive Assistant - assists with the processing of all the forms listed above:
- Executive Assistant – sends all completed forms via fax or email to Human Resources Department
- Forward all medical notes/bills and work status information to Human Resources Department

Human Resources Role

- Notifies the Treasurer's Department that employee is out on I.O.D. – Completes PAF
- Submits all medical bills for payment to Claims Services
- Follow-up with Claim Services regarding claims. Submits all claims/work status reports and medical notes to Claim Services.
- Keeps all copies in a separate employee Medical File "Confidential"
- Communicates with Chief or designee, Town Manager, employee, Executive Assistant and Claim Services regarding out of work status and claim processing.

Insurance Role

- Receives all Reports and accepts or denies claim.
- Follows up with HR & Benefits Coordinator with any issues and or concerns.
- Begins paying medical claims to doctor hospital

**Federal Insurance Company Police and Fire Accident Program
NOTICE OF CLAIM**

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 1, 3 and 5. The Claimant should: Complete and sign Sections 2, 3 and 4.

Section 1 – 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 2 – 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 2 – Claimant Information (continued)

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

Primary Occupation	Primary Occupation Work Hours	Name of Primary Occupation Employer	
Address of Primary Occupation Employer		Contact Phone Number	Contact Fax Number
Contact Name for Primary Occupation Employer		Exact duties unable to perform – Primary occupation	
Date last worked Primary Occupation Employer		Date returned to work – Primary Occupation Employer	
		<input type="checkbox"/> Full Duty <input type="checkbox"/> Light Duty	
Verification of Earnings <i>(Submit Primary Occupation pay stubs for the last 3 months. If self-employed, send copy of your prior year's tax return)</i>			
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 3 – Fraud Warning Statement – To be signed by policyholder and claimant

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.

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 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 4 – Medical Records Release

Forward Documentation to:

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

Date of Injury _____
(mm/dd/yyyy)

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 5 – Wage and Salary Verification

Forward Documentation to:

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

Date	Our Policyholder	Date of Injury	Claim Number
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EMPLOYER'S NAME AND ADDRESS	EMPLOYEE'S NAME AND ADDRESS
	Social Security No.:

OCCUPATION: _____

DATES OF EMPLOYMENT: From _____ through _____

Gross Earnings during 52-week period **PRIOR** to Accident: \$ _____

Wage or salary as of date of Accident:

a) \$ _____ Per Week Per Month

b) Usual number of days worked per week: _____

Dates Absent Following Accident:

a) Date Disability began: _____

b) Date returned to work _____

Was Employee paid during this absence: YES NO If YES, amount paid: \$ _____

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? _____

Is Employee eligible for any individual/group health insurance/HMO/other benefits? YES NO

Date: _____ Print Name & Title: _____

Telephone No.: _____ Signature _____

Thank you for your cooperation.





TOWN OF NORTH ATTLEBOROUGH Police & Firefighters Injured On Duty

SUPERVISOR'S ACCIDENT INVESTIGATION REPORT

*This form must be completed and sent to the Human Resources Department
within 24 hours after an accident*

Part 1 - General Information	Date of Report _____
Name of Employee: _____	Dept.: _____
Date of Accident: _____	Hour: ____ AM ____ PM Exact Location: _____
Job or Activity at Time of Accident _____	

Part 2 - Description of Accident

Part 3 - Cause of the Accident
Describe unsafe acts and/or conditions:

Part IV - Corrective Actions
What action has been taken or will be taken to correct the unsafe act and/or unsafe conditions?

Part V - Remarks

Signed: _____ (Chief And/Or Preparer)
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Town of North Attleborough

Police and Firefighters Injured on Duty

REFUSAL OF MEDICAL TREATMENT OR OBSERVATION AT THE TIME OF INCIDENT/INJURY

Employee's Name: _____ Department: _____

Date of Injury: _____

I, hereby acknowledge my refusal of medical treatment and/or observation offered to me at the expense of the Town of North Attleboro for the work-related injury. By signing this form, I realize that I do not necessarily affect my later eligibility for Workers' Compensation.

I acknowledge that my supervisor(s), in good faith, have offered and made available to me an opportunity to seek necessary medical treatment and/or observation. I am aware that by declining medical treatment at this time, that my employer, will not be responsible for any medical expenses or lost wages.

At a later time, I may request from my employer, via my supervisor, a medical authorization to obtain medical treatment and/or observation for the above described injury.

Employee's Signature

Date

Employee Representative/Witness

Date

