



Emergency Services Insurance Program
P.O. Box 5670, Cortland, New York 13045
Accident & Sickness Claim Notice for Emergency Service Personnel

TO BE COMPLETED BY THE MEMBER PRESENTING THE CLAIM

Name _____ Date of this Report _____
Telephone No. (_____) _____

Home Address _____ Social Security # _____

Date of Accident or Commencement of Sickness _____ Hour Occurred _____
Date of Birth _____ Height _____ Weight _____ Sex _____ Marital Status _____

Name of Emergency Service Organization _____
Address _____

Name of Regular Employer _____
Employer's Address _____ Phone (_____) _____
Length of Employment _____ Job Title _____ Average Monthly Income \$ _____
Description and Place of Accident/Exposure to Sickness. How did it occur? _____

Was your Injury a result of participation in an Organized League Sport? Yes No
What is your Injury or Sickness? _____

Date of first day of work missed at full time occupation. _____ Date you returned to work. _____
Attending Physician's Name and Address _____
Telephone (_____) _____

I certify that the information shown above is correct to the best of my knowledge and belief. I authorize any Health Care Provider, Insurance Company, Employer, Person or Organization to release any information regarding medical, dental, mental, alcohol or drug abuse history, treatment or benefits payable, including disability or employment related information to McNeil & Company, Inc./ Emergency Services Insurance Program or their employees and authorized agents for the purpose of validating and determining benefits payable. This data may be extracted for use in audit or statistical purposes. I understand that I or my authorized representative will receive a copy of the authorization request. This authorization or a photocopy of the original shall be valid for the duration of the claim.

X _____
Signature of Member Presenting the Claim _____ Date _____

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES A STATEMENT CONTAINING ANY MATERIAL FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

TO BE COMPLETED BY AN OFFICIAL OF THE ORGANIZATION OTHER THAN THE CLAIMANT

Is the Injured party a member of the organization? Yes No
Which of the following most closely describes the status of the injured party's membership/association with the Emergency Service Organization? Adult Volunteer Paid Career Junior Ladies Auxiliary Deputized Bystander
Was the individual involved in an authorized activity at the time of injury or commencement/exposure to sickness? _____
Certificate Number _____ Agent _____

Your Name _____ Title _____
Phone Number where you may be reached during normal business hours (_____) _____

X _____
Signature of Organization Official _____ Date _____

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