



HEALTH CARE PROVIDER'S STATEMENT

TO BE COMPLETED AND SIGNED BY THE MEMBER PRESENTING THE CLAIM

Date _____
Patient's Name _____
Address _____ Telephone (_____) _____
Name of Emergency Service Organization _____
Address _____

Certificate Number _____

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 _____ Date _____
Patient's / Claimant's Signature

TO BE COMPLETED AND SIGNED BY THE HEALTH CARE PROVIDER

THE COMPANY DOES NOT ASSUME ANY EXPENSE INCIDENTAL TO THE COMPLETION OF THIS FORM.

A. Present Condition _____
Diagnosis

Subject Symptoms _____

Objective Findings (X-Rays, E.K.G.'s, Laboratory Data and Clinical Findings) _____

_____ Date of last visit _____

When did symptoms first appear or accident happen? _____

Has the patient ever had the same or similar condition? _____ If so when? _____

Describe _____

Nature of surgical procedure if any (please describe in full) _____

B. Limitation (If there is a limitation, please check and describe below)

Standing Climbing Bending Use of Hands Sitting
Walking Stooping Lifting Psychological Other

C. Progress

Has Patient Recovered? Improved? Unchanged? Retrogressed?

Is Patient Bed Confined? Hospital Confined? Ambulatory? House Confined?

Has Patient been Hospital confined? Yes No If Yes, give name and address of Hospital _____
Confined from _____ Through _____

D. Cardiac (If Applicable)

Functional Capacity Class 1 (No Limitation) Class 2 (Slight Limitation)
(American Heart Assoc.) Class 3 (Marked Limitation) Class 4 (Complete Limitation)

Remarks _____

Blood Pressure (last visit) _____
Systolic Diastolic

THE HEALTH CARE PROVIDER MUST COMPLETE AND SIGN PAGE (2) OF THIS FORM.
A COPY OF THE PATIENT'S CHART MAY BE ATTACHED AS A SUPPLEMENT TO THIS FORM



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E. Extent of Disability

How long was or will Patient be Continuously Totally Disabled From _____ Through _____
(Unable to perform his or her regular occupation due to diagnosis on the previous page)

How long was or will the Patient be Partially Disabled From _____ Through _____

Approximate date that the Patient will return to work if still disabled _____

F. Mental / Nervous Impairment (If Applicable)

Please define "stress" as it applies to this claimant.

- Class 1 – Patient is able to function under stress and engage in interpersonal relationships (no limitations)
- Class 2 – Patient is able to function in most stress situations and engage in most interpersonal relations (slight limitations)
- Class 3 – Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations (moderate limitations)
- Class 4 – Patient is unable to engage in stress situations or engage in interpersonal relations (marked limitations)
- Class 5 – Patient has significant loss of psychological, physiological, personal and social adjustment (severe limitations)

G. Rehabilitation

Is the Patient a suitable candidate for rehabilitation? Yes No

H. Remarks _____

Health Care Provider's Name (Please Print) _____

Address _____

Telephone _____ Federal Tax I.D. Number _____

Signature _____ Date _____



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

THE TOP PORTION 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 FRAUD 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.

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

1. Is the Injured party a member of the organization? Yes No
2. 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
3. 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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