

Claim Filing Procedures - Police & Fire Accident Coverage
(Provided by Nationwide Ins. Co.)

If your police officer, firefighter or EMS provider is injured while on duty ...

1) Report the injury within 24 hours or as soon as notice is received.

- ✓ Download the new *First Notice of Injury* form, available at www.metrogard.com/Applications/Injury
- ✓ Have the injured employee's supervisor and the employee complete and sign the form.
- ✓ Fax or e-mail the completed form to **Trident Insurance Services of New England, Inc.:**

Fax: 617-830-0009

E-mail: Claims2@tridentinsurance.net

NOTE: If you prefer to send the form by mail, please use the address at the bottom of this sheet and send ATTN: Lynda DeMarino.

- ✓ Trident Claims will contact you within 24 hours of receiving the form to provide your case number and gather additional information.
- ✓ Please direct questions about the form or any aspect of your coverage to **Trident Claims** at: **866-650-4016, ext. 275.**

2. Send us all medical bills related to the injury.

- ✓ **Do not** send any medical bills until you have first submitted the *First Notice of Injury* form.
- ✓ **VERY IMPORTANT-- DO NOT pay medical bills and submit them to us for reimbursement or send them to any other insurance administrator.** Trident Claims must first review all bills to determine eligibility for compensation and to negotiate the lowest possible rates with medical providers.
- ✓ After claims are processed and payment has been made to providers, your designated Town official will receive an Explanation of Benefits (EOB) showing the patient's name, the original charge amount and the negotiated amount paid.
- ✓ **For Plans with Self-Funded Deductibles:** Trident will return medical bills to you showing the negotiated amount you are responsible for paying directly to the providers. Once our records show that the Town has fulfilled its deductible obligation, the insurance company will assume responsibility for paying the providers, subject to the policy provisions.

3. If you have purchased a Weekly Disability Income benefit:

- ✓ You will be asked for wage information for any injured-on-duty employee who is unable to work.
- ✓ Subject to the policy language, the insurance company will reimburse the Town for 80% of the employee's regular earned income up to the weekly maximum benefit and benefit term described in your policy.
- ✓ We will require the Town's Federal Tax Identification Number in order to mail a weekly reimbursement check, showing the name of the disabled employee, to the Town official that you designate to receive these funds.

NOTE: Claim Review, Investigations, Denials and Appeals

Every claim will be reviewed and investigated when appropriate to ensure that it should be filed with this plan. Claims will be denied which we determine are not work-related, incurred before or after your coverage period, or for other specific reasons described in your policy. If you feel a claim has been denied unfairly, you have the right to appeal the determination of coverage directly to the company.

First Notice of Injury – Medical or Disability

E M P L O Y E E	1. Employee's Name			2. Home Telephone	3. Social Security Number:	4. Sex:		
	Last	First	MI			<input type="checkbox"/> M	<input type="checkbox"/> F	
	5. Home Address (No. Street, City, State & Zip Code):							
6. Date of Hire (mm/dd/yyyy):			7. Date of Birth (mm/dd/yyyy):		8. Average Weekly Wage:			
						\$	<input type="checkbox"/> Estimated <input type="checkbox"/> Actual	
E M P L O Y E R	9. Employer's Name:							
	10. Employer's Address (No. Street, City, State & Zip Code):				11. Employer's Telephone Number:			
					12. Policy Number:			
A C C I D E N T / I N J U R Y I N F O R M A T I O N	13. Date of Injury or Accident:							
	14. Was Employee injured on Employer's Premises?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	15. Location of Injury if not on Employer's Premises:		
	16. Was Injury or Accident Caused by a Motor Vehicle?			<input type="checkbox"/> Yes	<input type="checkbox"/> No			
	17. Was Medical Attention Sought?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	18. If Yes, where:		
	19. First day of Total or Partial Disability to Earn Wages:				20. If Employee has Died, Date of Death :			
	21. Briefly Describe How Injury/Accident Occurred And Body Part(S) Involved:							
	22. Person To Whom The Injury Was Reported (List Position):				23. Date Reported:			
	24. Witness(es) to Injury – Give Full Names, if none state as such:							
	25. Has Employee Returned to Work?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	26. Date Employee Returned to Work:		
	27. Employee's Regular Occupation:				28. Has Employee Returned to Regular Occupation: <input type="checkbox"/> Yes <input type="checkbox"/> No			
29. Employee's Position <input type="checkbox"/> Fire <input type="checkbox"/> Police				30. <input type="checkbox"/> Career <input type="checkbox"/> Volunteer				
31. Comments:								
<p>Information Release: I hereby authorize the Trident Insurance Services of New England, Inc., or any of its representatives to be furnished only information and facts regarding medical services rendered to me by any medical provider, including reports/records, results of diagnosis, treatment and prognosis, estimates of disability and recommendations for further treatment. This information is to be used for the purpose of evaluating and handling my claim for injury as a result of an incident occurring on or about the above indicated date of injury for no other purpose, now or in the future. I attest that the information provided herein is true and accurate to the best of my knowledge.</p>								
Employee's Signature:				Date signed:				
Employer's Name:				Title:				
Employer's Signature:				Date Prepared:				
Please fax or email completed form to: Lynda DeMarino Trident Insurance Services of New England, Inc. 280 Summer Street, 4 th Floor Boston, MA 02210				Tel # 866-650-4016 ext. 275 Fax # 617-830-0009 Claims2@tridentinsurance.net				