PERSONNEL INJURY REPORT/FORMS

If you are injured, or become ill as a result of your employment seek medical attention immediately.

- **All Fire District Personnel, Career or Volunteer seeking medical assistance for such an injury or illness shall go to the appropriate medical facility as specified by Liberty Mutual in the accompanying document.**
- **All Fire District Personnel, Career or Volunteer seeking medical assistance for such an injury or illness shall notify their immediate supervisor as soon as is reasonable**
- **The forms attached here need to be completed as soon as is reasonably possible. Completed forms are to be forwarded to the Administrator so that they may be reported to the appropriate insurer.**

Enclosed you will find:

- **If You Are Injured At Work Flyer**
- **Liberty Mutual Insurance W C Report Form**
- **VFIS Accident/Sickness Claim Form**

IF YOU ARE INJURED AT WORK

FOR EMERGENCIES CALL 911

or go to the nearest hospital

Otherwise:

REPORT THE INJURY

To your supervisor

SEEK TREATMENT

From one of the doctors or clinics listed below.

MEDICAL PROVIDERS

Medexpress Urgent Care
118 E Hanover Ave
Cedar Knolls, NJ 07927
973-644-2223
Approximate Dist: 1.3 MI

Omni Med
131 Columbia Tpke Ste 3B
Florham Park, NJ 07932
973-377-8776
Approximate Dist: 4.2 MI

Med Express
128 Columbia Tpke Ste 101
Florham Park, NJ 07932
973-377-9366
Approximate Dist: 4.2 MI

Med Express
571 W Mount Pleasant Ave
Livingston, NJ 07039
973-992-4767
Approximate Dist: 5.4 MI

HOSPITALS

Morristown Medical Center
100 Madison Ave
Morristown, NJ 07960
201-292-3100
Approximate Dist: 2.5 MI

Saint Clares Hospital - Denville
25 Pocono Rd
Denville, NJ 07834
973-625-6000
Approximate Dist: 5.0 MI

HANOVER TWP BOFC #3 CEDAR KNOLLS FIRE DEPT
82 RIDGEDALE AVE
CEDAR KNOLLS NJ 07927
Created on: 08/25/2022

Liberty Mutual. INSURANCE

REPORT ALL WORKER'S COMPENSATION INJURIES TO LIBERTY MUTUAL INSURANCE
The 1-800 CLAIMS SERVICE CENTER is open 24 hours a day including Weekends and Holidays. For efficient service, have the following information available for the Customer Service Representative.

Liberty Mutual INSURANCE

Call: 1-800-362-0000

ExPRSCall W C Report Form

CLAIM INFORMATION

Date/Time of Injury: / / : am pm	After the call, write claim number here: **WC**
Is this claim work related? Yes O No O	Will the employee miss time from work? Yes O No O
Employer Name:	

EMPLOYEE INFORMATION

Employee's Social Security Number: - -	Employee's Name:
Home Address: (Street) (City) (State) (Zip)	
Home Phone Number: ( ) -	Male O Female O
Date of Birth:	Marital Status (circle one) Single Married Widowed Divorced
Hire Date:	Number of Dependents: Dependents Under 18:
Occupation:	Department Name:
State Hired:	Supervisor Name & Phone:
Current Weekly Wage:	Hourly Wage: Hours Worked Per Week:
Days Worked Per Week:	Hours Worked Per Day: Employment Status:
Employer Report No:	Employee ID No: Was Salary Continued:
Was Employee Paid in Full for Date of Injury:	How often is employee paid:
Education Level:	Any Prior WC Injuries: OSHA Reference No.:

EMPLOYER INFORMATION

Contact Name, Telephone Number, and Title:	
Work Location: (Street) (City) (State) (Zip)	
Mailing Addr: (Street) (City) (State) (Zip)	
Employer Location Code:	Employer SIC.:
Employer FED ID.:	Employer Code:
Nature of Business:	
Policy Number:	

ACCIDENT INFORMATION

Did the Accident Occur at the Work Location? Yes O No O If no, where did the accident occur?	
Accident Address: (Street) (City) (State) (Zip)	
Nature of Accident:	
Give a Full Description of the Accident: (Be As Complete As Possible)	
Are Other WC Claims Involved? Yes O No O	Date and Time Reported to Employer: : AM PM
Person Reported To:	

CONTINUED ON REVERSE SIDE

INJURY INFORMATION

Injury Description:

Date of Death *(If applicable)*:	Is Employee Hospitalized? Yes O No O
Lost Time? Yes O No O	If yes, What was First Full Day Out:
Date Last Day Worked:	Date Disability Began:
Date Returned to Work:	**OR** Estimated Return to Work Date:

Time Workday Began: : AM PM

Which Part of the Body Was Injured? (e.g. Head, Neck, Arm, Leg)	Nature of Injury: (e.g. Laceration, Bruise, Fracture)
Part of Body Location: (e.g. Left, Right, Upper, Lower)	Source of Injury:

MEDICAL INFORMATION

Safeguards Provided? Yes O No O	Safeguards Utilized? Yes O No O

Initial Medical Treatment: Circle One ER Treated and Released Hospitalized Physician/Clinic Minor/Onsite No Medical Treatment

Hospital - Name, Address, Phone, Fax:

Clinic/Doctor - Name, Address, Phone, Fax, Specialty:

WITNESS INFORMATION

Were There Any Witnesses? Yes O No O

If Yes, List Names and How to Contact Them:

ADDITIONAL COMMENTS & INFORMATION

REPORT PREPARED BY

Name: Title:

Signature: Phone: ( ) -

ACCIDENT/SICKNESS CLAIM REPORT

Please Complete and Mail to:

Glatfelter Claims Management, Inc.
P.O. Box 5126, York, PA 17405-9792
(800) 233-1957, Fax: (717)747-7051
claims@glatfelters.com

PLEASE COMPLETE THIS FORM IN FULL FOR PROMPT SERVICE

NOTE: Important State Information Included

DATE OF THIS REPORT _____

SECTION 1 – CLAIMANT INFORMATION

To be completed by the injured person, or next of kin if the claimant is unable or a fatality has occurred.

Home Phone (___) _____ Cell Phone (___) _____ Work Phone (___) _____

Name _____ Soc. Sec. No._____ Date of Birth _____

Home Address _____ City_____ State_____ Zip_____

Email Address _____ Weight _____ Height _____

Gender _____ Marital Status _____ Name of Spouse (if applicable) _____

Date of Incident or Organization's Activity _____ Year _____ Time_____ ☐ AM ☐ PM

Full-Time/Regular Occupation _____ Annual Income _____

Name/Address of Full-time Employer _____

Length of Employment in this Work _____ Employer's Phone Number _____

SECTION 2 – INCIDENT AND MEDICAL TREATMENT INFORMATION

1. What activity was the individual above involved in at the time of their injury or illness?

_____

2. How did the injury or illness occur?

_____

3. Please describe the injury or illness.

_____

4. Date of first day of full-time occupation missed due to above injury or illness (if applicable) _____ N/A ☐
5. Date able to return to work (if applicable) _____ N/A ☐
6. Attending Physician's Name, Address and Telephone Number _____
7. Name and Address of Hospital _____
8. Date Hospitalized From _____ To _____

SECTION 3 – AUTHORIZATION TO DOCTOR, HOSPITAL, CLINIC, EMPLOYER, INSURANCE COMPANY OR WORKERS' COMPENSATION CARRIER TO RELEASE MEDICAL INFORMATION

I authorize any Health Care Provider, Employer, Insurance Company, Workers' Compensation Carrier, Person or Organization to release information regarding my medical history, treatment, earnings, or benefits payable, including disability or employment related information, to Glatfelter Claims Management Inc., for the purpose of determining benefits that may be payable under the VFIS Accident and Sickness (A&S) policy. If medical benefits are determined to be payable under the VFIS A&S policy, I authorize payment to be made directly to my medical provider(s). A photocopy or digital copy of this authorization is valid in place of the form containing my original signature. This authorization shall be valid for the duration of my claim.

_____ _____ _____

Signature of Injured Member or Next of Kin | Relationship | Date

SECTION 4 – CERTIFICATION

To be completed by official of named insured organization (must be other than injured person)

- Was the injured person a member of your organization at the time of the above described incident? ☐ Yes ☐ No
- If claimant is a member of organization, please select type of member: ☐ Junior ☐ Adult ☐ Auxiliary
- Was the activity described in #1 above an authorized activity of the named insured organization? ☐ Yes ☐ No
- **Name and Address of Organization**
- Policy Number _____
- Organization Telephone Number _____
- Home Telephone Number of Official Signing Below _____

I certify that the above is true.

Signed_____ Title_____ Date _____

Print Name _____

Fraud Warning

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.

Applicable in Arizona

For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Applicable in California

For your protection California law requires the following to appear on this form: 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.

Applicable in Colorado

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages.

Applicable in Florida

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Applicable in New Jersey

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Applicable in 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.

Applicable in Pennsylvania

WARNING: Any person who knowingly and with intent to injure or defraud any insurer files an application or claim containing any false, incomplete or misleading information shall, upon conviction, be subject to imprisonment for up to seven years and the payment of a fine of up to $15,000.

Applicable in Rhode Island

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Applicable in West Virginia

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Applicable in All Other States

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.