Hamilton Township Fire District No. 3
Hamilton, New Jersey 08610

HEADQUARTERS:
RUSLING HOSE COMPANY
13 RENNIE STREET

TELEPHONE: (609) 392-1710
FAX: (609) 392-3403

Resolution #14-011
December 1, 2014

RESOLUTION OF GOVERNING BODY

WHEREAS, the FIRST Responder Joint Insurance Fund is authorized by statute to provide insurance coverage for local units of government who are desirous of same;

WHEREAS, Hamilton Township Fire District No. 3 is a member of the FIRST Responder Joint Insurance Fund;

WHEREAS, N.J.S.A. 59:8-6 authorized public entities to require information in addition to that specified in N.J.S.A. 59:8-4 for the proper investigation and/or resolution of such claims; and

WHEREAS, the FIRST Responder Joint Insurance Fund has recommended that each of the participating public entities adopt and approve a Notice of Tort Claim form in the form attached to this resolution;

NOW, THEREFORE, BE IT RESOLVED by the Board of Fire Commissioners of Hamilton Township Fire District No. 3 that:

1. Hamilton Township Fire District No. 3 hereby adopts and approves the attached Notice of Claim form pursuant to N.J.S.A. 59:8-6;

2. Nothing in this resolution shall be construed as invalidating any Notice of Claim form authorized by Hamilton Township Fire District No. 3 and/or the FIRST Responder Joint Insurance Fund prior to the implementation of this resolution.

IT IS HEREBY CERTIFIED THAT THIS IS A TRUE COPY OF THE RESOLUTION PASSED AT THE MEETING HELD ON DECEMBER 1, 2014.

Gilbert W. Lugossy, Secretary

Dec. 1, 2014
Date

Board of Commissioners Recorded Vote

Member	Aye	Nay	Abstain	Absent
Joseph Zalescik	✓			
Gilbert Lugossy	✓			
David Brenner	✓			
James Gramigna				✓
Patrick Gribbin	✓			

FIRST RESPONDER JOINT INSURANCE FUND
NOTICE OF CLAIM

Forward to:

1. Claimant:

Last First Middle — Area Code/Telephone Number

Street Address — City State/Zip Code

Date of Birth — Social Security Number — E Mail Address

2. If notices and correspondence in connection with this claim are to be sent to a person other than claimant, please complete this section.

Name — Street Address

Additional Address — City State/Zip Code

Area Code/Telephone Number — Relationship to Claimant

3. Accident:

A. The occurrence or accident which gave rise to this claim:

Date — Time

B. Describe the location or place of the accident or occurrence:

Local Unit — Exact Location of the Occurrence

C. Describe how the accident or occurrence happened. If a diagram will assist your explanation, please use the reverse side of this form.

D. State the name and address of the Local Unit that you claim caused your damage.

E. State the names of the Local Unit's employees whom you claim were at fault, including any information that will assist in identifying them.

F. State in detail each and every negligent or wrongful act of the Local Unit and the Local Unit's employees which caused your damage.

G. State the name and address of all witnesses to the accident or occurrence.

H. If vehicle accident, state the names, address, age, and relationship to insured of all passengers in your vehicle.

_____

_____

_____

I. State the names of all police officers and police departments who investigated the accident.

_____

_____

_____

4. Claim for damages:

A. Claim for damages: (Check appropriate box)

_____Bodily Injury _____Property Damage _____Other

If other, explain _____

_____

B. i. If you claim bodily injury – describe your injuries resulting from this accident or occurrence.

_____

_____

_____

ii. Do you claim permanent disability resulting from this injury?

_____

_____

_____

iii. For each hospital, doctor or other practitioner rendering treatment, examination or diagnostic service, please list:

Name of Hospital, Doctor, or other Facility

Address | City | State/Zip Code

Date of Treatment | Amount of Charges

Amount Paid if Payable by other sources, i.e., insurance.

iv. If you claim loss of wages or income as a result of the injury, state:

Name of Employer | Your Occupation

Address | City | State/Zip Code

Date Employed at this Job | Rate of Pay

Dates of Absences from Work | Total Lost Wages to Date

If still out of work, expected date of return.

NOTE: If your claimed loss of income arises from self-employment or other wages, attach a calculation showing the basis of your calculation of lost income.

v. Set forth any and all other losses or damages claimed by you.

C. If you claim property damage:

i. Describe the property damaged. If vehicle, include make, model, year, color, vehicle identification number, license plate number, state, and parts of vehicle damaged.

_____

_____

_____

ii. The present location and time when the property can be inspected.

_____

_____

_____

iii. Date property acquired _____

iv. Cost of the property _____

v. Value of property at time of accident _____

vi. Description of damage:

_____

_____

_____

vii. Has the damage been repaired?

_____ Yes _____ No

If yes, by whom, and cost of repairs.

_____

_____

viii. Attach each estimate of repair costs to this form.

ix. Set forth in detail the loss claimed by you for property damage.

_____

_____

_____

D. Set forth in detail all other items of loss or damages claimed by you and the method by which you made the calculation.

_____

_____

_____

_____

5. The amount of the claim _____

6. Have you made a claim against anyone else for any of the losses or expenses claimed in this notice?

_____ Yes _____ No

If yes, set forth the names and address of all persons and the insurance companies against whom you have made such claims.

_____

_____

_____

7. Are any of the losses or expenses claimed herein covered by any policy of insurance?

_____ Yes _____ No

For each such policy, state the name and address of the insurance company, policy number, and benefits paid or payable.

_____

_____

8. Have you received or agreed to receive any money from anyone for damages claimed herein?

_____ Yes _____ No

If yes, set forth the details of such agreement.

_____

_____

_____

_____

_____

The following items must be submitted with this notice:

1. Copies of itemized bills for each medical expense and other losses and expenses claimed.

2. Full copies of all appraisals and estimates of property damage claimed by you.

3. Copies of all written reports of all expert witnesses and treating physicians.

4. A letter from your employer verifying your lost wages. If self-employed, a statement showing the calculation of your claimed lost income.

I hereby certify that the foregoing statements made by me are true, that the attached statements, bills, reports, and documents are the only ones known to me to be in existence at this time. I am aware that if any statement made herein is willfully false or fraudulent, I am subject to punishment as provided by law.

_____ _____

Date Claimant or person filing on behalf of claimant.

_____

Print name as signed above.

Authorization for Medical Reports and Records

To: (Doctor's Name and Address)

Re: Claimant:
Claim Number:
Social Security Number:
Date of Birth:

I. Pursuant to my privacy rights under the Health Insurance Portability and Accountability Act (HIPPA), by affixing my signature below I understand and voluntarily consent to the following:

I hereby request and authorize that you disclose, make available and furnish to:

Highland Claim Services, Inc.
PO Box 222
McAfee, NJ 07428

Or the attorney/authorized representative all medical records and reports including:

1.) Office notes; 2.) Charts: 3.)Diagrams; 4.) pathology reports; 5.) Operative reports; 6.) Physical and lab tests; 7.) X-ray/imaging reports; 8.) X-ray/Imaging films; 9.) Prescription notes; 10.) Treatment plans; and 11.) Discharge summary with regard to the above name individual, from the inception of your records to the present.

This authorization specifically excludes the release of health information related to the psychiatric or mental health treatment, treatment of drug and/or alcohol abuse; treatment of Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV); and sexually transmitted diseases/viruses.

II. Rights and obligations under HIPPA:

A. Purpose of this request: I understand that the information listed above in Section I. is being requested by Highland Claim Services, Inc. for the specific purpose of investigation a pending claim. By signing the authorization, I voluntarily consent to its release.

B. Expiration Date: Unless otherwise revoked, this authorization will expire six (6) months after the date of this authorization;

C. Right to revoke: I understand that I have the right to revoke this authorization at any time. I understand that the revocation must be in writing to the above named doctor/facility authorized to make this disclosure. I further understand that the revocation is only effective after it is received by the above named doctor/facility and does not apply to information that has already been released in response to the authorization.

D. Impact on Medical Treatment: I understand that my right to treatment, payment, enrollment or eligibility for benefits is not a condition on me signing this authorization.

E. Subsequent Disclosure: I understand that any disclosure of information may be subject to re-disclosure by Highland Claim Services, Inc. and my no longer be protected by federal or state law.

_____ _____
Signature of Claimant Date

_____ _____
Signature of Authorized Representative Date
Guardian in lieu of Claimant

By signing this authorization, the Authorized Representative and/or Guardian certified that he or she has the authority to act on behalf of the person identified above on the basis of (please explain):

Authorization for Information on Employment

TO WHOM IT MAY CONCERN:

I hereby authorize_____
To release any and all information concerning my employment, past or present, include rate of pay, duties performed, date of absences and reasons therefore. Photostat copies of this Authorization carry the same Authority as the original.

_____ _____
Date Signature

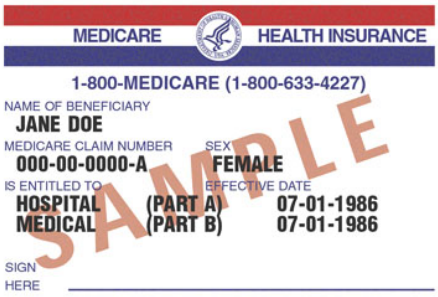
_____
Print name as signed above

The Centers for Medicare & Medicaid Services (CMS) is the federal agency that oversees the Medicare program. Many Medicare beneficiaries have other insurance in addition to their Medicare benefits. Sometimes, Medicare is supposed to pay after the other insurance. However, if certain other insurance delays payment, Medicare may make a "conditional payment" so as not to inconvenience the beneficiary, and recover after the other insurance pays.

Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA), a new federal law that became effective January 1, 2009, requires that liability insurers (including self-insurers), no-fault insurers, and workers' compensation plans report specific information about Medicare beneficiaries who have other insurance coverage. This reporting is to assist CMS and other insurance plans to properly coordinate payment of benefits among plans so that your claims are paid promptly and correctly.

We are asking you to the answer the questions below so that we may comply with this law.

Please review this picture of the Medicare card to determine if you have, or have ever had a similar Medicare card.



Section I

Are you presently, or have you ever been, enrolled in Medicare Part A or Part B?	☐ Yes	☐ No

If yes, please complete the following. If no, proceed to Section II.

Full Name: (*Please print the name exactly as it appears on your SSN or Medicare card if available.*)

Medicare Claim Number:	**Date of Birth (Mo/Day/Year)**	- -
Social Security Number: *(If Medicare Claim Number is Unavaiable)*	- -	**Sex:** ☐ Female ☐ Male

Section II

I understand that the information requested is to assist the requesting insurance arrangement to accurately Coordinate benefits with Medicare and to meet its mandatory reporting obligations under Medicare law.

Claimant Name (Please Print) _____ **Claim Number** _____

Name of Person Completing This Form If Claimant is Unable (Please Print) _____

Signature of Person Completing This Form _____ **Date** _____

If you have completed Sections I and II above, stop here. If you are refusing to provide the information requested in Sections I and II, proceed to Section III.

Section III

_____ _____

Claimant Name (Please Print) **Claim Number**

For the reason(s) listed below, I have not provided the information requested. I understand that if I am a Medicare beneficiary and I do not provide the requested information, I may be violating obligations as a beneficiary to assist Medicare in coordinating benefits to pay my claims correctly and promptly.

Reason(s) for Refusal to Provide Requested Information:

_____

_____

_____

_____

_____ _____

Signature of Person Completing This Form **Date**