New York State Public Employees Federation AFL-CIO
Membership Benefits Program
40 British American Blvd.
Latham, NY 12110

(800) 767-1840
(518) 785-1900, ext. 243
(518) 783-5339 *(Fax)*
email: mbp@pef.org
pefmbp.com

Dear Valued PEF Member:

Attached is the PEF Membership Benefits Program Assault, Trauma, and Captivity (ATAC) Claim packet. The PEF Membership Benefits Program (PEF MBP) insures PEF members for the trauma associated with an assault or hostage situation that occurs while a member is in pursuit of his/her occupational duties.

To submit a claim, please complete the enclosed Claim Form and Release Form. To allow for the processing of your claim in a timely manner, please have your doctor complete the enclosed Attending Physician's Statement and submit to PEF MBP along with your claim form, release, and the additional documents listed below:

- ☐ Attending Physician's Statement completed by your doctor.
- ☐ A police or peace officer report, signed by an officer, indicating that you have, or will be pressing assault charges. Or, an agency report (not just supervisor) with either security or member indicating why police did not respond and/or why police cannot file charges.
- ☐ Medical records, discharge instructions, description of care, and any out of work notes proving you sought immediate (within 24 hours) medical attention following the assault.
- ☐ A time sheet, signed/approved by your supervisor, showing you worked on the date of the assault and time missed immediately after the incident.

Please be sure you complete the claim packet in its entirety. An incomplete packet could result in a delay in processing your claim.

If you have any questions or need assistance filing your claim, please feel free to contact Ryan Gilligan, Senior Benefits Service Representative, at (800) 767-1840 or (518) 785-1900, ext. 227.

Please be advised that you may be eligible for additional benefits from the New York State Crime Victims Board. For information regarding eligibility and benefits, please visit www.ovs.ny.gov, or call (800) 247-8035.

We understand this is a difficult time for you, and it is our goal to make the claims process as easy as possible. We appreciate your trust in the PEF Membership Benefits Program and the ATAC benefit we provide.

Sincerely,

PEF Membership Benefits Program
Assault, Trauma, and Captivity Program

Enc/rg

PEF MBP Trustees: Bernadette O'Connor, *Chair* | Wayne Spence | Randi DiAntonio | Barbara Stransky | Raymond Moroz
PEF Membership Benefits Program Administrator: Stephanie McLean-Beathley

ASSAULT, TRAUMA, AND CAPTIVITY CLAIM FORM

FORM MUST BE COMPLETED BY PEF MEMBER. Please type or print CLEARLY.

SECTION 1

Name of Member:	Membership Identification # (MIN):	
Address (street, city, state, zip code):	Work #: Home #:	
	Occupation:	
Work Address (street, city, state, zip code):	Date of Incident: _____/_____/_____	Time of Incident: _____ AM / PM
Has a Workers' Compensation claim been filed? ☐ YES ☐ NO	What injuries were received?	

Describe incident in detail (Use separate sheet if necessary):

_____

_____

_____

NOTE: ALL OF THE INFORMATION BELOW AND SUPPORTING DOCUMENTATION MUST BE SUBMITTED WITH YOUR CLAIM.

Was immediate first aid sought? ☐ YES ☐ NO If yes, give name and address of:

Doctor: _____

Hospital: _____

Other: _____

Was incident reported to police or other agency? ☐ YES ☐ NO

If yes, give name and address of department or agency:_____

Is the Police Report attached? ☐ YES ☐ NO Are you willing to press charges? ☐ YES ☐ NO

Is the Attending Physician's Statement attached? ☐ YES ☐ NO

Are your medical records, discharge instructions, and any other appropriate documents included that prove you sought immediate attention following your assault? ☐ YES ☐ NO

Are copies of your time sheets, showing proof of five (5) consecutive days of missed work, signed by your supervisor, and attached? ☐ YES ☐ NO

SECTION 2

To all physicians, hospitals, medical service providers, druggists, employers, consumer reporting agencies, law enforcement agencies, and any other agencies or organizations (including other Insurance companies, Blue Cross-Blue-Shield, self-insured and prepaid health plans):

You are authorized to permit the PEF Membership Benefits Program and the authorized representatives to view and obtain a copy of ALL RECORDS including employment, law enforcement, financial, insurance claim records, and medical records as to examination history, diagnosis, treatment, and prognosis with respect to any physical or mental condition including psychiatric, drug, or alcohol treatment.

Print name of Member_____

AUTHORIZATION MUST BE SIGNED BY MEMBER OR SPOUSE/DOMESTIC PARTNER

I understand the information obtained will only be used by the PEF Membership Benefits Program to determine eligibility for insurance and benefits claimed under the member's policy. I consent to the redisclosure of such information to reinsuring companies, The Medical Information Bureau, and such other persons or organizations performing business or legal services in connection with my claim, or as may be otherwise lawfully required. Such information will not be given, sold, transferred, or relayed to any other person not specified in this form without my written consent.

I understand this authorization may be revoked by written notice to the PEF Membership Benefits Program, but this will not apply to information already released. If not revoked, this authorization will be valid while the claim is pending, but not to exceed a maximum of two years from the date below.

I understand I may request a copy of this authorization. I also agree that a photographic copy of this authorization shall be as valid as the original.

_____ _____/_____/_____

(Limitations if any) *(Date)* *(Signature*)* *(If other than member, state relationship)*

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

If a signature is provided by a legal representative (i.e., Attorney, in Fact, guardian, or conservator), please attach documentation of legal status.

* To insert your electronic signature, click Fill & Sign on the right navigation, or under Tools, then click on the Sign symbol at the top of the PDF. Create your signature and place on the signature line.

Please email your form to mbinsurance@pef.org or, print and mail your form to the PEF Membership Benefits Program, 40 British American Blvd., Latham, NY 12110

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ASSAULT, TRAUMA, AND CAPTIVITY

Authorization to Obtain and Release Information

AUTHORIZATION TO RELEASE INFORMATION

- I understand that the information obtained will be used solely by the New York State Public Employees Federation (PEF) Membership Benefits Program.
- I understand and agree that this information will be used for the purpose of evaluating active, dues-paying members who have been assaulted while in the pursuit of his/her occupational duties. Any information obtained will not be released by the New York State Public Employees Federation Membership Benefits Program to any person or organization.
- Information concerning Social Security benefits including, but not limited to, monthly benefit amounts, monthly payment amounts, entitlement dates, and information for applying for permanent, total disability resulting from an assault or captivity, need to be provided.
- I acknowledge and agree that any restrictions I have made to protect my health information, does not apply to this authorization and I instruct the person(s) and organization(s) identified above, to release and disclose my entire medical record without restrictions.
- I acknowledge that I have read the authorization. A photocopy or facsimile of this authorization is as valid as the original and will be provided to me upon request.

This authorization is given in connection with the Assault, Trauma and Captivity claim for benefits. I intend for this authorization to be valid for the duration of the claim. A photocopy or facsimile of this authorization shall be valid as the original.

PEF Member's Name (please print): _____

PEF Membership Identification Number (MIN): _____

Date: _____ Signature of Member*: _____

* To insert your electronic signature, click Fill & Sign on the right navigation, or under Tools, then click on the Sign symbol at the top of the PDF. Create your signature and place on the signature line.

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ATTENDING PHYSICIAN'S STATEMENT

It will be a service to your patient if you will please answer all questions completely.

Patient Name:		
What is the present diagnosis?	Physical Limitations:	
Is Patient still under your care for this condition? □ **YES** □ **NO**	If "NO", give date your services terminated: _____/_____/_____	
Frequency of visits: □ **Daily** □ **Weekly** □ **Monthly** □ **Other**_____		
Date of your first treatment: ____/____/____ Date of last visit: ____/____/____ (enclose copy of office notes from that visit)		
Have any complications developed? □ **YES** □ **NO**	If "YES", what?	
Has any operation been: □ Performed? □ **Recommended?** □ **Scheduled**?	What?	When: _____/_____/_____
Since last Report, has the Patient been hospital confined? □ **YES** □ **NO**	Where?	When? _____/_____/_____

PROGNOSIS FOR REGULAR WORK	PROGNOSIS FOR GAINFUL WORK
Is Patient, disabled and unable to perform his/her regular work? □ **YES** □ **NO** _____/_____/____ First date unable to work: _____/_____/____ Date Patient can return to work:____/_____/_____	Is Patient, disabled and unable to perform any gainful occupation? If "NO", date released to return to regular work. □ **YES** □ **NO** _____/_____/____
Do you expect a fundamental or marked change in the future relating to Patient's job? □ **YES** - **Improvement** □ **YES** - **Deterioration** □ **NO**	Do you expect a fundamental or marked change in the future relating to any occupation? □ **YES** - **Improvement** □ **YES –Deterioration** □ **NO**
If "NO", please explain:	If "NO", please explain:
If improvement is expected, when will patient recover sufficiently to perform duties of his/ her regular work? **(Do not respond with Undetermined)** _____/_____/_____	If improvement is expected, when will patient recover sufficiently to perform duties of any gainful occupation? **(Do not respond with Undetermined)** _____/_____/_____

COMMENTS:

Name of Attending Physician (Please Print):	Degree/Specialty:	Telephone Number: ( )
Physician's Address (Street, City, State, Zip):		
Date Signed: _____/_____/_____	Signature of Attending Physician: x	