



New York State Public Employees Federation AFL-CIO

Membership Benefits Program

10 Airline Drive, Suite 101
Albany, NY 12205

(518) 785-1900, ext. 243

(800) 767-1840

(518) 783-5339 (Fax)

www.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 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, ext. 227, 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



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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.

Please email your form to mbinsurance@pef.org or, print and mail your form to the PEF Membership Benefits Program, 10 Airline Drive, Suite 101, Albany, NY 12205

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



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? <input type="checkbox"/> YES <input type="checkbox"/> NO	If "NO", give date your services terminated: ____/____/____	
Frequency of visits: <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other _____		
Date of your first treatment: ____/____/____ Date of last visit: ____/____/____ (enclose copy of office notes from that visit)		
Have any complications developed? <input type="checkbox"/> YES <input type="checkbox"/> NO	If "YES", what? _____	
Has any operation been: <input type="checkbox"/> Performed? <input type="checkbox"/> Recommended? <input type="checkbox"/> Scheduled?	What? _____	When: ____/____/____
Since last Report, has the Patient been hospital confined? <input type="checkbox"/> YES <input type="checkbox"/> NO	Where? _____	When? ____/____/____
PROGNOSIS FOR REGULAR WORK	PROGNOSIS FOR GAINFUL WORK	
Is Patient, disabled and unable to perform his/her regular work? <input type="checkbox"/> YES <input type="checkbox"/> 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. <input type="checkbox"/> YES <input type="checkbox"/> NO ____/____/____	
Do you expect a fundamental or marked change in the future relating to Patient's job? <input type="checkbox"/> YES - Improvement <input type="checkbox"/> YES - Deterioration <input type="checkbox"/> NO	Do you expect a fundamental or marked change in the future relating to any occupation? <input type="checkbox"/> YES - Improvement <input type="checkbox"/> YES -Deterioration <input type="checkbox"/> 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 _____	