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) 342-4306, ext. 243
(518) 783-5339 *(Fax)*
www.pefmbp.com

Dear Valued PEF Member:

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

To submit a claim, please complete the enclosed Claim Form and Release. Please bring the Attending Physician's Statement to your doctor's office to be completed by your doctor. We also require the following information to process your claim in a timely manner:

- A police or peace officer report, signed by an officer, indicating that you have or will be pressing assault charges.
- Proof that you sought immediate medical attention following the assault, including initial visit medical records, discharge instructions, and any out of work notes.
- Copies of your time sheets with your supervisor's signature, to show proof of five (5) consecutive days of missed work. Time sheets must include the date of the assault, and the five or more missed days. Please note pass days or regular days off can be included in the five consecutive days of missed work.

If you have any questions or need assistance filing your claim, please feel free to contact Samantha Kalbfliesh at (800) 342-4306 ext. 296, or (518) 785-1900 ext. 296. You can also see additional information on our website, www.pefmbp.com.

You may also 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 benefit we provide.

Sincerely,

PEF Membership Benefits Program
Assault, Trauma, and Captivity Program

Enc/smk

MEMBERSHIP BENEFITS PROGRAM

ASSAULT, TRAUMA, AND CAPTIVITY CLAIM FORM

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

SECTION 1

Name of Member:	**Social Security #:**	
Address (street, city, state, zip code):	**Work #:**	**Home #:**
Occupation:	**Agency:** **Location:**	**Division:**
Work Address (street, city, state, zip code):	**Date Last Worked:** _____/_____/_____	**Date of Incident:** _____/_____/_____ **Time of Incident:** _____ **AM PM**
Place of Incident: ☐ **Work** ☐ **Recreation** ☐ **Home** ☐ **Highway** ☐ **Other**_____	**What Injuries were Received?**	

Describe Incident in Detail (Use Separate Sheet if Necessary):

Has worker's compensation claim been presented? ☐ **YES** ☐ **NO**

Was immediate first aid sought? ☐ **YES** ☐ **NO** **If "Yes," give names 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 Police Report attached? ☐ **YES** ☐ **NO** **Are you willing to press charges?** ☐ **YES** ☐ **NO**

Is Attending Physician's Statement completed? ☐ **YES** ☐ **NO** **Is copy of timecard attached?** ☐ **YES** ☐ **NO**

NOTE: ALL OF THE ABOVE INFORMATION IS NEEDED TO PROCESS CLAIM.

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 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 DEPENDENT

I understand the information obtained will only be used by 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 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.

Revised 5/18

Please return to: PEF Membership Benefits Program, 10 Airline Drive, Suite 101, Albany, NY 12205

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	

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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 persons and organizations identified above, to release and disclose my entire medical record without restrictions.
- I acknowledge that I have read the authorization. A photo copy 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 photo copy 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: _____

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