NOTICE OF CLAIM

Forward to:

1. Claimant:

Last First Middle

Area Code/Telephone Number

Street Address

Additional Address

Date of Birth

Social Security Number

City State/Zip Code

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.
78 Route 23 North, Suite 2
Hamburg, NJ 07419

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 therefor. Photostat copies of this Authorization carry the same Authority as the original.

_____ _____
Date Signature

_____
Print name as signed above