THE HARTFORD

Notice of Claim

The Regents of the University of California Cooperative Extension

Mail Forms To: P.O. Box 189 Bridgton, ME 04009 - Phone: 1-888-998-2240 - Fax: 1-207-647-4569

POLICYHOLDER CERTIFICATION - To be completed by Policyholder Official (UC 4-H YDP Staff)

** Due to new government regulations, claims submitted without this data will be returned.*

Policyholder Number ☐ **57 SR 560999 - Acc** ☐ **57 CH 144856 - Sickness**

Policyholder Name **The Regents of the University of California Cooperative Extension**

Policyholder Phone Number **(530) 754-8518**

Agent Name **Assured Partners**	Agent Phone Number **(800) 545-3090 Ext: 275**

Claimant (Injured Party) Name	Claimant Gender ☐ Man/Boy ☐ Woman/Girl ☐ Nonbinary
Claimant Date of Birth	☐ Gender Not Listed ☐ Prefer Not to Respond

*Is the Claimant a Medicare Beneficiary? ☐ No ☐ Yes

If yes, please provide Claimant's Social Security Number or Health Identification Claim Number _____

Claimant Address (Street Number, City, State & Zip Code)	Claimant Phone Number ( )

Date of Accident _____ (mm/dd/yyyy)	Time of Accident (hh:mm) _____ ☐ AM ☐ PM	Indicate injured body part(s)

Cause of Accident	Place of Accident
Witness to the Accident (Name)	Supervisor of the activity

Nature of Sickness (if applicable)	Date Sickness first commenced

Policyholder Certification Signature Required

I hereby certify the Claimant is a volunteer or a member of the group insured under the above Policy and the injury/ sickness was sustained under adequate supervision while participating in an official Covered Activity. I further certify I have **read and signed** the Fraud Warning statement located on the bottom of this form.

Title of Policyholder Official (UC 4-H YDP Staff)	Signature of Policyholder Official (UC 4-H YDP Staff)	Date

FRAUD WARNING CERTIFICATION - To be signed by Policyholder, Adult Volunteer/Witness and Parent/Guardian or Adult Claimant.

For residents of California: For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Signature of Policyholder Official (UC 4-H YDP Staff)	Date
Signature of UC 4-H Adult Volunteer/or Adult Witness	Date
Signature of Parent/Guardian or Adult Claimant	Date