

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 <input type="checkbox"/> 57 SR 560999 - Acc <input type="checkbox"/> 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 <input type="checkbox"/> Man/Boy <input type="checkbox"/> Woman/Girl <input type="checkbox"/> Nonbinary	
Claimant Date of Birth	<input type="checkbox"/> Gender Not Listed <input type="checkbox"/> Prefer Not to Respond	
*Is the Claimant a Medicare Beneficiary? <input type="checkbox"/> No <input type="checkbox"/> 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) _____ <input type="checkbox"/> AM <input type="checkbox"/> 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
<i>Policyholder Certification Signature Required</i>		
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

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