TRIDENT

Member Argo Group

Police & Fire Injury Form – Medical or Disability

EMPLOYEE

1. Employee's Name			2. Home Telephone	3. Social Security Number:	4. Sex:
Last	First	MI			☐ M ☐ F

5. Home Address (No. Street, City, State & Zip Code):

8. Date of Hire (mm/dd/yyyy):	9. Date of Birth (mm/dd/yyyy):	10. Average Weekly Wage:
		$ ☐ Estimated ☐ Actual

EMPLOYER

11. Employer's Name:

12. Employer's Address (No. Street, City, State & Zip Code):	13. Employer's Telephone Number:
	14. Policy Number:

ACCIDENT INJURY INFORMATION

15. Date of Injury or Accident:

16. Was Employee injured on Employer's Premises?	☐ Yes	☐ No	17. Location of Injury if not on Employer's Premises:
18. Was Injury or Accident Caused by a Motor Vehicle?	☐ Yes	☐ No	
19. Was Medical Attention Sought?	☐ Yes	☐ No	20. If Yes, where:

21 First day of Total or Partial Incapacity to Earn Wages:	22. If Employee has Died, Date of Death :

23. Briefly Describe How Injury/Accident Occurred And Body Part(S) Involved:

24. Person To Whom The Injury Was Reported (List Position):	25. Date Reported:

26. Witness(es) to Injury – Give Full Names, if none state as such:

27. Has Employee Returned to Work?	☐ Yes	☐ No	28. Date Employee Returned to Work:

29. Will (or has) employee file(d) for Unemployment Compensation or for Disability Benefits provided by any Employer-Employee, Labor Management, or Union Welfare Plan? ☐ Yes ☐ No

If yes, please specify:

30. Describe any other income Employee is receiving or is eligible to receive as a result of disability/injury: (Example: Salary Continuance, Employer Disability, Social Security, Workers' Compensation, Unemployment Compensation, State Disability, Pension Disability, Union Welfare Plan, etc.

Describe Source:	Amount of Income:	Date of Income:	Date Income Ended/Ends:

31. Employee's Regular Occupation:	32. Has Employee Returned to Regular Occupation: ☐ Yes ☐ No

33. Comments:	
Information Release: I hereby authorize the Trident Insurance Services of New England, Inc.,, or any of its representatives to be furnished only information and facts regarding medical services rendered to me by any medical provider, including reports/records, results of diagnosis, treatment and prognosis, estimates of disability and recommendations for further treatment. This information is to be used for the purpose of evaluating and handling my claim for injury as a result of an incident occurring on or about the above indicated date of injury for no other purpose, now or in the future.	
34. Employee's Signature: _____	35. Date signed:
36. Employer's Name:	37. Title:
38. Employer's Signature:	39. Date Prepared:
Please fax or email completed form to: **Trident Insurance Services of New England, Inc.** **280 Summer Street, 4th Floor,** **Boston, MA 02210**	**Tel # 866-650-4016 ext. 209** **Fax # 617-830-0009** **Claims2@tridentinsurance.net**