2018 Claim Reporting and Management

900 Route Nine North, Suite 503, Woodbridge, NJ 07095
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Main Number: (732) 634-8400
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GARDEN STATE MUNICIPAL JOINT INSURANCE FUND **January 2018**

Claims Management

- Property, Auto and Liability Claims are managed by the NIP Group Team in Woodbridge NJ
- Workers Compensation Claims are managed by the Qual- Lynx Team in Piscataway NJ
- Attached is staff information which identifies the teams who manage PAL and WC Claims.

All Claims Are Reported Through the Qual – Lynx In Take Procedures

Multiple Options For Claim Reporting

- On –Line through Wed based Reporting Tool 'Risk Console' at Qual-Lynx .com
    - For instructions on how to obtain login credentials, see below section entitled 'Claim Coordinator and Access for Electronic Reporting'
- Dedicated GSMJIF E Mail Address GardenStateJIFClaims@qual-lynx.com attach the appropriate Acord form and send as an attachment
- Fax Property, Auto, Liability Claims – 609.365.4998 using appropriate Acord form
- Fax Workers Compensation Claims – 732-465-7355 use workers compensation Acord form
- Workers compensation call in number – 1.800.425.3222

Claim Coordinator and Access for Electronic Reporting

Please identify who will be the Claim Coordinator or Designated Claim Contact.

The following information should be sent to Teresa Drummond (tdrummond@qual-lynx.com) or Client Services (qual-lynxclientservices@qual-lynx.com) for new members joining the GSMJIF to receive login credentials for Online Claim Reporting with a copy to Renee Nelms (rnelms@qual-lynx.com):

- GSMJIF Member
- First and Last Name of Coordinator / Claim Contact
- Job Title
- Business Address & Phone Number
- Fax Number
- Email Address
- Please Identify additional users for Electronic Reporting, Name, Phone Number, Title and or job function

Qual – Lynx Reporting Guidelines

- Brief Instructions for reporting Property , Liability, Automobile and Workers Compensation Losses

Qual – Lynx Acord Forms

- Fillable Acord forms .pdfs are included to Email or Fax
- Once filled please print, scan and e-mail to the dedicated GSMJIF e-mail address (GardenStateJIFClaims@qual-lynx.com)
- When e-mailing please indicate in the subject line 'First notice of loss by business line as well as the member'
- i.e. First Notice of Loss – WC/GL/ - Member Name

Qual –Lynx Contact for Online Claim Reporting Assistance

- Help Desk 609.653.8400 ext. 2094 or Qual-LynxClientServices@Qual-lynx.com
- Client Services Manager, Teresa Drummond
    - 609.653.8400 Ext. 3280, tdrummond@qual-lynx.com

GSMJIF Worker's Compensation First Report of Injury / Employee Accident Form

- First report of Injury form may be used in place of an Acord form, sent via fax or e-mail.
- Accident form may be used to conduct an internal investigation including prior medical history
- Please print each form out separately from this packet by using page ranges in your printers prompt window or by copy and pasting them in their entirety into a new Word document

Information Needed to Investigate & Adjust the Claim

- **First-Party Property Claims**
  1. Loss Location (address & description of property)
  2. Loss Description
  3. Description of Damaged Property
  4. Amount of Approximate Damages

- **Automobile Accident Claims**
  1. Loss Description
  2. Description of Damaged Property
  3. Copy of Police Accident Report
  4. Estimate of Damages for Township Vehicle
  5. Copy of the Tort Claim Notice from Claimant (required for 3rd party claims)

- **Third-Party Liability Claims**
  1. Loss Location (address & description of property)
  2. Information Regarding Who is Responsible for the Loss Location (Municipal, County, State, Residential or Commercial)
  3. Loss Description
  4. Identity & Contact Information for Claimant
  5. Description of Damaged Property or Claimant's Injuries
  6. Claimant's Allegations
  7. Estimate of Damages
  8. The Date (with documentation) that the Township was First Put on Notice of a Dangerous Condition of Public Property
  6. Copy of the Tort Claim Notice from Claimant (required for 3rd party claims)

- **Police Professional Claims**
  1. Loss Description
  2. Description of Damaged Property or Claimant's Injuries
  3. Identity & Contact Information for Claimant
  4. Claimant's Allegations
  5. Copy of the Tort Claim Notice from Claimant (required for 3rd party claims)
  6. Police Incident Report (Upon Request)
  7. Dash Cam or Video Surveillance Camera Footage (Upon Request)
  8. IA Records of the Accused Officers (Upon Request)

- **Public Official's Liability Claims**
  1. Loss Description
  2. Description of Damaged Property or Claimant's Injuries
  3. Identity & Contact Information for Claimant
  4. Claimant's Allegations
  5. Copy of the Tort Claim Notice from Claimant (required for 3rd party claims)

- **Employment Liability Claims**
  1. Copy of the Claim Notice
  2. Copy of the Law Suit Filed (if applicable)

Information Needed to Investigate & Adjust the Claim

- **Workers' Compensation Claims**
  1. Employer Name
  2. Claimant Name/Address/Phone Number/Marital Status/Social Security No.
  3. Claimant Date of Birth
  4. Claimant Occupation (note full-time, part-time or volunteer)
  5. Claimant Average Weekly Wage
  6. Accident Date
  7. Date Accident was Reported
  8. Person Claim was Reported to
  9. Accident Description
  10. Accident Location
  11. Injury Description
  12. Medical Facility
  13. Name and Contact Information for Claimant's Supervisor
  14. Witnesses
  15. Lost Time from Work?
  16. Date Lost Time Commenced

Worker's Compensation – First Report of Injury

EMPLOYER/MEMBER

Contact Name	
Address (Please include ZIP)	
Phone Number	( ) - -

CARRIER / CLAIMS ADMINISTRATOR

Carrier	Garden State Municipal Joint Insurance Fund
Third Party Claims Administrator	Qual-Lynx
Third Party Claims Administrator Address	30 Knightsbridge Rd, Piscataway, NJ 08854

EMPLOYEE INFORMATION

Name (Last, First, Middle)	
Address (Please Include ZIP)	
E-mail Address	
Phone Number	
Sex / Marital Status / Number of Dependents	
Date of Birth	
Social Security Number	
Date Hired	
Occupation / Job Title	
Rate of Pay / Average Weekly Wages	
Number of Days Worked per Week	

Full pay for day of injury? **(Y / N)** Did salary continue? **(Y / N)**

OCCURENCE

Time Employee Began Work	
Date and Time of Injury or Illness	
Last Worked Date	
Date Employer Notified	
Date Disability Began	
Type of Injury / Illness	
Part of Body Affected	

Did the Injury / Illness Exposure Occur on Employer's Premises? **(Y / N)**

Please give a complete description of the accident. Include any objects or substances that directly injured the employee:

Has the employee returned to work? (Y / N)

TREATMENT

Physician / Health Care Provider Name	
Physician / Health Care Provider Address	
Date of Treatment	
Hospital or Offsite Treatment Location	

Please describe the initial treatment (none, minor- employer, minor - clinic, emergency care, overnight hospitalization, major hospitalization requiring future lost time):

WITNESSES

Witness Name(s)	
Phone Number(s)	

Employee Accident Form

EMPLOYEE NAME	I.D.	TIME OF INJURY	DATE OF INJURY	FILE NUMBER
PLEASE LIST YOUR PRIMARY CARE PHYSICIAN AND HIS/HER ADDRESS FOR THE PAST TEN YEARS				
BRIEFLY DESCRIBE HOW YOU GOT HURT AND WHEN THE INJURY OR ILLNESS OCCURRED.				
WHAT PART(S) OF THE BODY WERE HURT; AND IN WHAT PART(S) OF THE BODY DO YOU CURRENTLY FEEL PAIN?				
HAVE YOU HAD TREATMENT IN THE PAST FOR THE SAME OR SIMILAR MEDICAL CONDITION? ☐ YES☐ NO IF YES, PLEASE PROVIDE THE NAME AND ADDRESS OF THE TREATING PHYSICIAN(S) FOR THIS CONDITION. LIST ANY MEDICATIONS YOU ARE OR WERE TAKING FOR THIS CONDITION/INJURY?				
HAVE YOU BEEN TREATED IN THE PAST BY A CHIROPRACTOR? ☐ YES☐ NO IF YES, PLEASE PROVIDE THE NAME AND ADDRESS OF THE CHIROPRACTOR(S).				
HAVE YOU FILED ANY WORKERS' COMPENSATION CLAIM(S) IN THE PAST FOR THIS MEDICAL CONDITION? ☐ YES☐ NO IF YES, PLEASE PROVIDE THE DETAILS OF THE PREVIOUS CLAIM(S).				
HAVE YOU EVER BEEN INVOLVED IN ANY MOTOR VEHICLE COLLISIONS? ☐ YES☐ NO IF YES, PLEASE PROVIDE THE DETAILS OF THE CRASH, DATE, AND THE NATURE OF THE INJURY AND TREATMENT.				
ARE YOU CURRENTLY ENGAGED IN ANY OTHER EMPLOYMENT OR HAVE YOU EVER BEEN ENGAGED IN ANY OTHER EMPLOYMENT WHILE YOU WERE EMPLOYED BY US? ☐ YES☐ NO IF YES, PLEASE LIST THE NAMES AND ADDRESSES OF THESE EMPLOYERS.				

DO YOU CURRENTLY (IN THE PAST 12 MONTHS) PARTICIPATE IN ANY ATHLETIC, RECREATIONAL OR SPORTING ACTIVITIES? ☐ YES☐ NO IF YES, PLEASE LIST THE ACTIVITIES YOU PARTICIPATE IN.
TO WHOM DID YOU FIRST REPORT THE INJURY TO AND WHEN?
WERE THERE ANY WITNESSES TO YOUR INJURY? IF SO, WHO?
HAVE YOU EVER RECEIVED PAIN MANAGEMENT TREATMENT? IF SO, BY WHOM?

I CERTIFY THAT THE ABOVE STATEMENTS MADE BY ME ARE TRUE AND CORRECT. I AM AWARE THAT IF ANY OF THE STATEMENTS ARE WILLFULLY FALSE, I MAY BE SUBJECT TO DISCIPLINARY ACTION BY MY EMPLOYER.

EMPLOYEE SIGNATURE	SUPERVISOR'S SIGNATURE AND I.D.	DATE

NIP CLAIM CONTACTS:

Conrad Cyriax

Senior Vice President, Chief Claim Officer

TEL: (732) 362-5714

MOBILE: (732) 642-3550

FAX: (732) 791-1642

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ROBERT PERSICO

AVP of Workers Compensation Claims

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JAMES RENNER

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CHRISTOPHER VOGT

Claims Representative

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ELIZABETH SHEERAN

Claims Representative

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DONNA GARTLAND

Claims Representative

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Qual-Lynx Claims WC Team – Garden State Municipal JIF

FAX: 732-465-7355

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