Small Cities Organized Risk Effort
A Joint Powers Authority

CLAIMS REPORTING MANUAL

FY 24/25

PRESENTED BY:
ALLIANT INSURANCE SERVICES
2180 HARVARD STREET STE 460
SACRAMENTO, CA 95815

VERSION 7.0

CLAIMS REPORTING MANUAL FY 24/25

Contents

Members Participating in Liability Program 2
Liability Claims Contacts 3
Client Responsibilities for Reporting Claims 3
Members Participating in Workers' Compensation Program 4
Workers' Compensation Claims Contacts 5
Client Responsibilities for Reporting Claims 5
Members Participating in APIP Property Program 6
APIP Property Claims Contacts 7
Client Responsibilities for Reporting Claims 7
Members Participating in APIP Cyber Program 8
APIP Cyber Claims Contacts 9
Client Responsibilities for Reporting Claims 9
Members Participating in APIP Pollution Program 10
APIP Pollution Claims Contacts 11
Client Responsibilities for Reporting Claims 11
Members Participating in PRISM Pollution Program 12
PRISM Pollution Claims Contacts 13
Client Responsibilities for Reporting Claims 13
Members Participating in ACIP Crime Program 14
Alliant Crime (ACIP) Claims Contacts 15
Client Responsibilities for Reporting Claims 15
Members Participating in ERMA Employement Practices Liability Program 16
ERMA Employment Practice Liability Claims Contacts 17
Client Responsibilities for Reporting Claims 17
Members Participating in Identity Fraud Program 18
Crime – Identity Fraud Claims Contacts 19
Client Responsibilities for Reporting Claims 19
Members Participating in Alliant Deadly Weapons Response Program 18
Crime – Alliant Deadly Weapons Response Claims Contacts 21
Client Responsibilities for Reporting Claims 21
Members Participating in Alliant Mobile Vehicle Program 22
Alliant Mobile Vehicle Program Claims Contacts 23
Client Responsibilities for Reporting Claims 23

SCORE MEMBER PARTICIPATION FY 24/25

City of Biggs
City Of Colfax
City Of Dunsmuir
City Of Etna
City Of Isleton
City Of Live Oak
Town Of Loomis
City Of Loyalton
City Of Montague
City Of Mount Shasta
City Of Portola
City Of Rio Dell
City Of Shasta Lake
City Of Susanville
City Of Tulelake
City Of Weed
City Of Yreka

George Hills
PO Box 278
Rancho Cordova, CA 95741

Policy Period	Services Performed By:	Services Performed For:
July 1, 2024 – June 30, 2025	George Hills PO Box 278 Rancho Cordova, CA 95741	Small Cities Organized Risk Effort 2180 Harvard Street STE 460 Sacramento, CA 95815

Liability Claims Contacts

i	***Rose Melchor — Liability Claims Supervisor*** ***Phone: 916-375-9722 Email: rose.melchor@georgehills.com***
i	***Dana Calkins — Senior Liability Adjuster*** ***Phone: 916-333-0575 Email: dana.calkins@georgehills.com***
i	***Tina Wolf — Liability Adjuster*** ***Phone: 909-505-0794 Email: tina.wolf@georgehills.com***
i	***Mayra Curiel — Claims Processor*** ***Phone: 909-281-1966 Email: Mayra.Curiel @georgehills.com***
i	***Tammy Hunt — Subrogation Supervisor*** ***Phone: 916-233-2544 Email: Tammy.Hunt@georgehills.com***
i	***Kathleen Proctor — Client Services Manager*** ***Phone: 916-467-8126 Email: Kathleen.proctor@georgehills.com***
i	***Marcus Beverly — First Vice President, CPCU, AIC, ARM-P*** ***2180 Harvard Street STE 460, Sacramento, CA 95815*** ***Phone: 916-643-2704 Email: Marcus.Beverly@alliant.com***
i	***Michelle Minnick — Account Manager*** ***2180 Harvard Street STE 460, Sacramento, CA 95815*** ***Phone: 916-643-2715 Email: Michelle.Minnick@alliant.com***

Client Responsibilities for Reporting Claims

- **All new losses should be reported via email sent to: *MyGHCNewClaims@georgehills.com* with the following information in the subject line: "SCORE - NEW CLAIM – CITY NAME"**
- **Subrogation Only Claims should be reported via email: subro@georgehills.com**
- Emergency or After Hours Calls George Hills Answering Service: 855-442-2357
- Be sure to include Alliant Program Administration Staff in communications with the Liability Claims Department.
- For Automobile incidents, be sure to complete the DMV SR-1 form to report a traffic accident occurring in California. The form should be submitted directly to the DMV using the address noted on the form

A Public Service Agency

REPORT OF TRAFFIC ACCIDENT OCCURRING IN CALIFORNIA

Please type or print.

# OF VEHICLES	DATE OF ACCIDENT	ACCIDENT LOCATION (*CITY/COUNTY*) (***CALIFORNIA ONLY***)	ON PRIVATE PROPERTY ☐ Yes ☐ No

REPORTING PARTY'S INFORMATION

TIME OF ACCIDENT Hour ______ ☐ AM ☐ PM | ☐ Moving ☐ Stopped in Traffic ☐ Parked ☐ Pedestrian ☐ Bicyclist ☐ Other (*E.G., ROLLAWAY*) | DRIVING FOR EMPLOYER ☐ Yes ☐ No

DRIVER'S NAME (*FIRST, MIDDLE, LAST*)	DRIVER LICENSE NUMBER	STATE

DRIVER'S STREET ADDRESS	DATE OF BIRTH

CITY	STATE	ZIP CODE	TELEPHONE NUMBERS Wk ( ) Hm ( )

VEHICLE (*YEAR AND MAKE*)	VEHICLE LICENSE PLATE **OR** VEHICLE IDENTIFICATION NUMBER	STATE	DAMAGES OVER $1,000 ☐ Yes ☐ No

VEHICLE OWNER (*PERSON OR COMPANY*)	DATE OF BIRTH

ADDRESS	CITY	STATE	ZIP CODE

INSURANCE COMPANY NAME *(NOT AGENT OR BROKER)* AT THE TIME OF THE ACCIDENT	POLICY NUMBER

COMPANY NAIC NUMBER	POLICY PERIOD From: ______ To: ______	POLICY HOLDER NAME

OTHER PARTY'S INFORMATION

☐ Moving ☐ Stopped in Traffic ☐ Parked ☐ Pedestrian ☐ Bicyclist ☐ Other (*E.G., ROLLAWAY*) | DRIVING FOR EMPLOYER ☐ Yes ☐ No

DRIVER'S NAME (*FIRST, MIDDLE, LAST*)	DRIVER LICENSE NUMBER	STATE

DRIVER'S STREET ADDRESS	DATE OF BIRTH

CITY	STATE	ZIP CODE	TELEPHONE NUMBERS Wk ( ) Hm ( )

VEHICLE (*YEAR AND MAKE*)	VEHICLE LICENSE PLATE **OR** VEHICLE IDENTIFICATION NUMBER	STATE	DAMAGES OVER $1,000 ☐ Yes ☐ No

VEHICLE OWNER (*PERSON OR COMPANY*)	DATE OF BIRTH

ADDRESS	CITY	STATE	ZIP CODE

INSURANCE COMPANY NAME *(NOT AGENT OR BROKER)* AT THE TIME OF THE ACCIDENT	POLICY NUMBER

COMPANY NAIC NUMBER	POLICY PERIOD From: ______ To: ______	POLICY HOLDER NAME

INJURY/DEATH PROPERTY DAMAGE

NAME AND ADDRESS OF INDIVIDUAL INJURED OR DECEASED	☐ Injured ☐ Deceased	☐ Driver ☐ Passenger ☐ Bicyclist ☐ Pedestrian
NAME AND ADDRESS OF INDIVIDUAL INJURED OR DECEASED	☐ Injured ☐ Deceased	☐ Driver ☐ Passenger ☐ Bicyclist ☐ Pedestrian

OTHER PROPERTY DAMAGED (*TELEPHONE POLES, FENCE, LIVESTOCK, ETC.*)	DAMAGES OVER $1,000 ☐ Yes ☐ No

PROPERTY OWNER'S NAME AND ADDRESS

READ IMPORTANT INFORMATION ON BACK

I certify (or declare) under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

DATE	PRINTED NAME	SIGNATURE **X**

☐ ADDITIONAL INFORMATION ATTACHED

A	**YOUR VEHICLE**	**CALIFORNIA INSURANCE INFORMATION** The Department may send this part to the **insurance company** indicated. If not **fully completed**, it will be assumed you were **not** insured for the accident and **your license will be suspended.**	**DO NOT DETACH**	**DMV FILE NUMBER**

INSURANCE

NAME OF INSURANCE COMPANY (*NOT AGENT OR BROKER*) THAT ISSUED THE LIABILITY POLICY COVERING THE OPERATION OF YOUR VEHICLE				
POLICY NUMBER	POLICY PERIOD From: ______ To: ______		DRIVER LICENSE NUMBER (*DRIVER OF YOUR VEHICLE*)	
DATE OF ACCIDENT	IN OR NEAR (*CITY OR TOWN*) (*CALIFORNIA ONLY*)			
VEHICLE (*YEAR AND MAKE*)	VEHICLE IDENTIFICATION NUMBER		VEHICLE LICENSE PLATE NUMBER	STATE
DRIVER	ADDRESS			
OWNER	ADDRESS			
FULL NAME OF POLICY HOLDER	ADDRESS			

SR 1A (REV. 1/2017) **WWW**

If the policy was not in effect, this form must be completed and returned to DMV within 20 days.

The undersigned company advises that with respect to the reported accident, the policy reported on the reverse side:

☐ **WAS NOT** IN EFFECT

☐ Was not a liability policy ☐ Did not cover the vehicle/driver ☐ Number is not a company policy number

Policy Number ______________________ Policy Period from ____________ to ____________

Signature ______________________

Title ______________________

Date ______________________

MAIL TO:
Department of Motor Vehicles
P.O. Box 942884
Sacramento, CA 94284-0884

IMPORTANT INFORMATION

California law requires *traffic accidents* on a California street/highway or private property to be reported to the Department of Motor Vehicles (DMV) within 10 days if there was an injury, death *or* property damage in excess of $1,000. Untimely reporting could result in DMV suspending a driver license. Accidents involving vehicles *not required to be registered* such as an off-road vehicle (OHV), implement of husbandry, or snowmobile **or** occurring on a military base **or** occurring on the driver's *own* property involving *only* the personal property of the driver *and* there was no injury or death are not reportable.

The law requires the driver to file **this SR 1 form** with DMV **regardless of fault**. This report must be made in addition to any other report filed with a law enforcement agency, insurance company, or the California Highway Patrol (CHP) as their reports **do not** satisfy the filing requirement. An insurance agent, attorney, or other designated representative may file the report for the driver.

The law requires every driver and every owner of a motor vehicle to be "financially responsible" for any injury or damage resulting from operating or owning a motor vehicle. The minimum insurance level for "financial responsibility" is **public liability and property damage coverage** of $15,000 for injury or death of one person, $30,000 for injury or death of two or more persons and $5,000 property damage per accident. Comprehensive and collision insurance **does not meet the legal requirement.**

The *California Vehicle Code* (CVC) §1806 requires DMV to record accident information **regardless of fault** when individuals report accidents under the Financial Responsibility Law or if law enforcement agencies or CHP investigate and make a report.

WHEN COMPLETING THIS FORM...

Please print within the spaces and boxes on this form. If you need to provide additional information on a separate piece of paper(s) or you include a *copy* of any law enforcement agency report, please check the box to indicate 'Additional Information Attached'. **If you are the passenger reporting the accident**, be sure to identify yourself by using the 'other' box and stating 'passenger' in the explanation.

- Write **unk (for unknown)** or **none** in any space or box when you do not have information on the other party involved.
- Give insurance information that is complete and which *correctly* and *fully* identifies the **company** that *issued* the policy.
- Place the correct National Association of Insurance Commissioners (NAIC) number for your insurance company in the boxes provided. The NAIC number should be located on your insurance ID card or you can contact your insurance agent or company for the information.
- Identify any person involved in the accident (driver, passenger, bicyclist, pedestrian, etc.) who you saw was injured *or* complained of bodily injury or know to be deceased.
- Record in the OTHER PROPERTY DAMAGED section any damage to telephone poles, fences, street signs, guard posts, trees, livestock, dogs, etc., meeting the filing requirement, including amount. T*his may require that you contact the owner of the property for an estimate of damages.*
- Once you have completed this report, please mail it to:

Department of Motor Vehicles
Financial Responsibility
Mail Station J237
P.O. Box 942884
Sacramento, CA 94284-0884

DMV does not accept reports or take actions against non-reporting or uninsured motorists unless this SR 1 form is sent to DMV by someone involved in the accident or their designee and the report is received by DMV *within one calendar year of the accident date.*

ADVISORY STATEMENT

The accident information on the SR 1 is required under the authority of Divisions 6 and 7 of the CVC. Failure to provide the information will result in suspension of the driving privilege. Except as made confidential by law (e.g., medical information) or exempted under the Public Records Act, the information is a public record, is regularly used by law enforcement agencies and insurance companies, and is open to public inspection. CVC §16005 limits the public record for SR 1 reports to accident involvement, but does allow persons with a proper interest (involved drivers, their employers, etc.) to receive specified information. Individuals may inspect or obtain copies of information contained in their records during regular office hours. The Financial Responsibility Unit Manager, 2570 24th Street, Sacramento, CA 95818 (telephone number: 916-657-6677) is responsible for maintaining this information.

SCORE MEMBER PARTICIPATION FY 24/25

City of Biggs
City Of Colfax
City Of Dunsmuir
City Of Etna
City Of Live Oak
Town Of Loomis
City Of Loyalton
City Of Montague
City Of Mount Shasta
City Of Portola
City Of Rio Dell
City Of Shasta Lake
City Of Susanville
City Of Tulelake
City Of Weed
City Of Yreka

Intercare
6020 West Oaks Blv., Suite 100
Rocklin, CA 95765

Policy Period	**Services Performed By:**	**Services Performed For:**
July 1, 2024 – June 30, 2025	Intercare 6020 West Oaks Blvd STE 100 Rocklin, CA 95765	Small Cities Organized Risk Effort 2180 Harvard Street STE 460 Sacramento, CA 95815

Workers' Compensation Claims Contacts

Shawna Culp — Claims Manager
Phone: 916-277-2526 Email: SCulp@Intercareins.com

LuAnn Koppel — ACP, WC Claims Operations
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Heather Spain — Senior Claims Adjuster
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Ebony Aleksich — Claims Supervisor
Phone: 916-780-3628 Email: ealeksich@Intercareins.com

Danielle Buri-Beaton — Sr. Vice President of Client Services
Phone: 916-277-2526 Email: DBuri@Intercareins.com

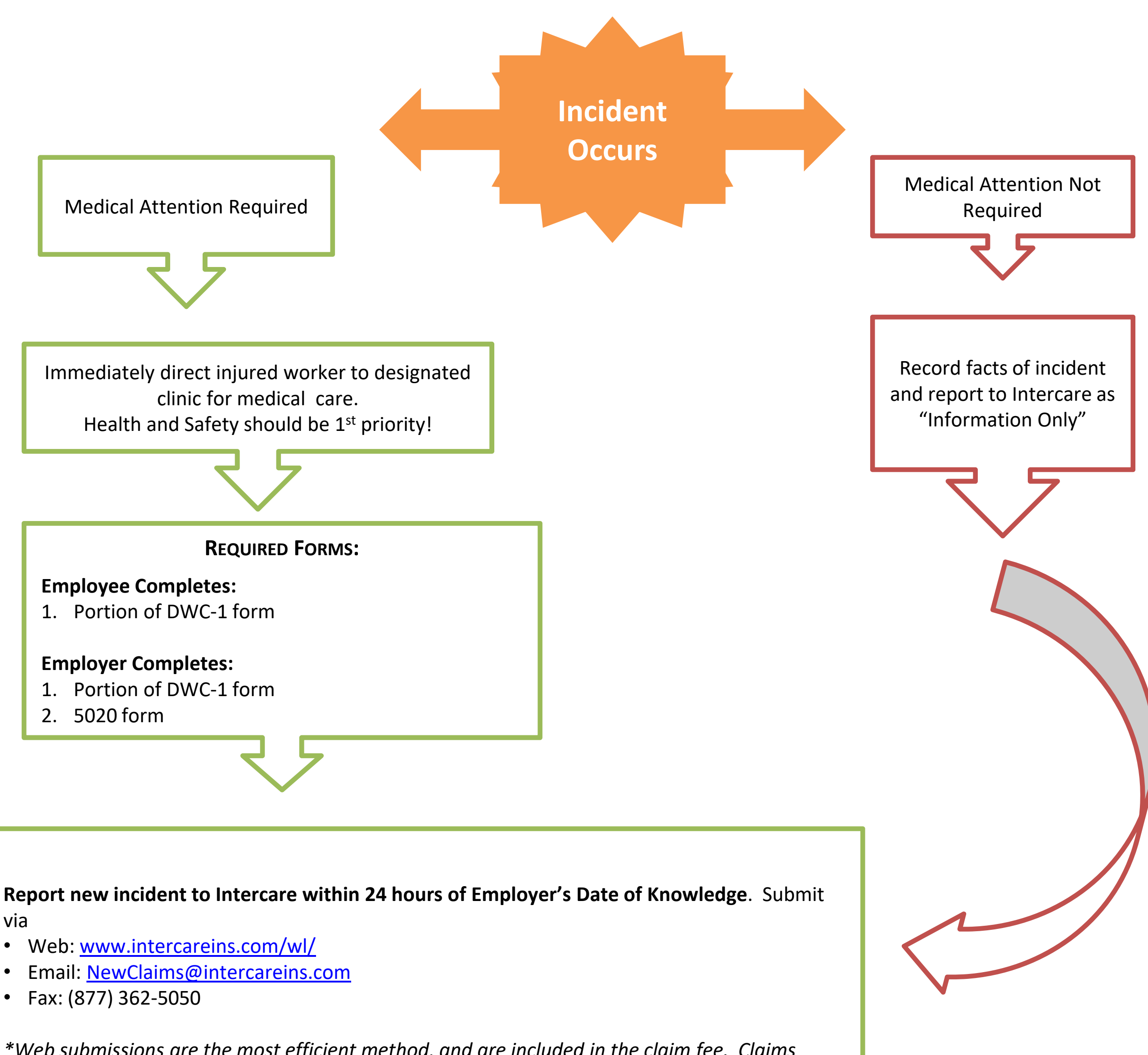
Marcus Beverly — First Vice President, CPCU, AIC, ARM-P
2180 Harvard Street STE 460, Sacramento, CA 95815
Phone: 916-643-2704 Email: Marcus.Beverly@alliant.com

Michelle Minnick — Account Manager
2180 Harvard Street STE 460, Sacramento, CA 95815
Phone: 916-643-2715 Email: Michelle.Minnick@alliant.com

Client Responsibilities for Reporting Claims

- Supervisor should complete the following within 24 hours of knowledge of an injury or receipt of DWC-1 form:
  1. Bottom portion of DWC-1 lines 10-19 (Mandatory)
  2. Supervisor's Report of Injury
- The City or Town should complete the following within 24 hours of knowledge of an injury:
  1. Employer's Report of Injury, form 5020 (Mandatory) either submit online via web at www.intercareins.com/wl/ or email NewClaims@intercareins.com
  2. Email or fax the DWC-1, Supervisor's Report, any medical reports or work status slips, or any other pertinent information via web at www.intercareins.com/wl/ or email NewClaims@intercareins.com or fax to 877.362.5050

intercare



If claim is reported via Web, e-acknowledgement is sent to client.

New claim submitted by Client to Intercare via
Web: www.intercareins.com/wl/
Email: NewClaims@intercareins.com
Fax: (877) 362-5050

A copy of a 5020 is transmitted to client & the 5020 data is transmitted to CA DOI via Electronic submission

The New Claims Department will import new claims into the claims system.

A copy of 5020 is simultaneously transmitted to Nurse Case Manager for triage

Triage Nurse completes review & provides recommendation

SUPERVISOR REVIEWS NEW CLAIM:

- Assign to adjuster
- Provide guidance & diary to follow up
- Approve ongoing Case Management involvement, if appropriate

ADJUSTER CONDUCTS:

- 3-pt contact & preliminary investigation w/in 2 business days
- Document findings & formulate plan of action
- Set appropriate diaries
- Set appropriate reserves based on probable outcome

DECISION PROCESS:

- **Accept:** Pay benefits, direct & control medical treatment & move case to closure
- **Delay:** AOE/COE Investigation & determine factual dispute; if med issue, gather medical history & secure medical opinion to determine cause
- **Deny:** Denial letter based on affirmative defenses

Adjuster receives claim assignment from supervisor

Conducts initial investigation including 3-pt contact (ER, EE & Phys)

DELAY

Make decision within 14 days of knowledge

Dispute Period (90 days):

- Finalize 3-point contact to all parties, contact the injured employee to discuss delay process, and establish reserves based on most probable outcome
- Medical Issue – Obtain medical history, secure medical opinion to address causation
- Factual Issue – Determine factual dispute, frame issues and proceed with AOE/COE

Complete investigation within 90 days

Re-evaluate reserves and adjust accordingly

ACCEPT

Make decision within 14 days of knowledge

- Finalize 3-point contact to all parties, contact the injured employee, and establish reserves based on most probable outcome
- Initiate benefit payments – calculate AWW, TD rate, and verify lost time with employer. Contact the injured employee every 14-30 days while off work
- Direct, control and manage treatment plan

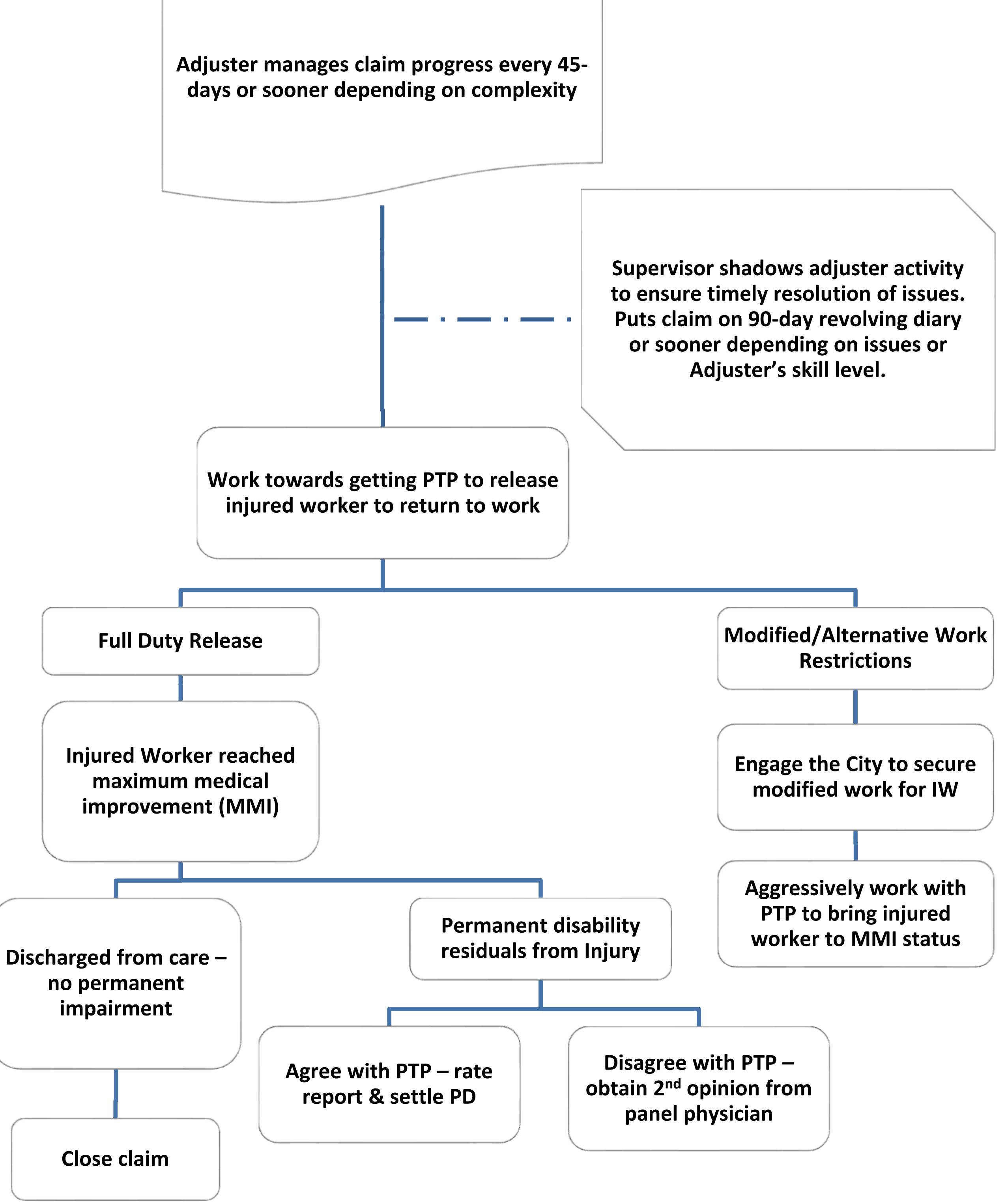
Manage claim for developmental progress (P&S, QIW, PD, treatment, etc.) Document activity and action plan accordingly. Adjust as warranted.

Re-evaluate reserves as necessary and adjust accordingly

DENY

Make decision within 14 days of knowledge

- Finalize 3-point contact to all parties, contact the injured employee with decision, and establish reserves based on most probable outcome
- Initiate benefit payments – calculate AWW, TD rate, verify lost time with employer
- Direct, control and manage treatment plan


Adjuster manages claim progress every 45-days or sooner depending on complexity
Supervisor shadows adjuster activity to ensure timely resolution of issues. Puts claim on 90-day revolving diary or sooner depending on issues or Adjuster's skill level.
Work towards getting PTP to release injured worker to return to work
Full Duty Release
Modified/Alternative Work Restrictions
Injured Worker reached maximum medical improvement (MMI)
Engage the City to secure modified work for IW
Aggressively work with PTP to bring injured worker to MMI status
Discharged from care – no permanent impairment
Permanent disability residuals from Injury
Agree with PTP – rate report & settle PD
Disagree with PTP – obtain 2nd opinion from panel physician
Close claim

Workers' Compensation Claim Form (DWC 1) & Notice of Potential Eligibility

Formulario de Reclamo de Compensación de Trabajadores (DWC 1) y Notificación de Posible Elegibilidad

If you are injured or become ill, either physically or mentally, because of your job, including injuries resulting from a workplace crime, you may be entitled to workers' compensation benefits. Use the attached form to file a workers' compensation claim with your employer. **You should read all of the information below.** Keep this sheet and all other papers for your records. You may be eligible for some or all of the benefits listed depending on the nature of your claim. If you file a claim, the claims administrator, who is responsible for handling your claim, must notify you within 14 days whether your claim is accepted or whether additional investigation is needed.

To file a claim, complete the "Employee" section of the form, keep one copy and give the rest to your employer. Do this right away to avoid problems with your claim. In some cases, benefits will not start until you inform your employer about your injury by filing a claim form. Describe your injury completely. Include every part of your body affected by the injury. If you mail the form to your employer, use first-class or certified mail. If you buy a return receipt, you will be able to prove that the claim form was mailed and when it was delivered. Within one working day after you file the claim form, your employer must complete the "Employer" section, give you a dated copy, keep one copy, and send one to the claims administrator.

Medical Care: Your claims administrator will pay for all reasonable and necessary medical care for your work injury or illness. Medical benefits are subject to approval and may include treatment by a doctor, hospital services, physical therapy, lab tests, x-rays, medicines, equipment and travel costs. Your claims administrator will pay the costs of approved medical services directly so you should never see a bill. There are limits on chiropractic, physical therapy, and other occupational therapy visits.

The Primary Treating Physician (PTP) is the doctor with the overall responsibility for treatment of your injury or illness.

- If you previously designated your personal physician or a medical group, you may see your personal physician or the medical group after you are injured.
- If your employer is using a medical provider network (MPN) or Health Care Organization (HCO), in most cases, you will be treated in the MPN or HCO unless you predesignated your personal physician or a medical group. An MPN is a group of health care providers who provide treatment to workers injured on the job. You should receive information from your employer if you are covered by an HCO or a MPN. Contact your employer for more information.
- If your employer is not using an MPN or HCO, in most cases, the claims administrator can choose the doctor who first treats you unless you predesignated your personal physician or a medical group.
- If your employer has not put up a poster describing your rights to workers' compensation, you may be able to be treated by your personal physician right after you are injured.

Within one working day after you file a claim form, your employer or the claims administrator must authorize up to $10,000 in treatment for your injury, consistent with the applicable treating guidelines until the claim is accepted or rejected. If the employer or claims administrator does not authorize treatment right away, talk to your supervisor, someone else in management, or the claims administrator. Ask for treatment to be authorized right now, while waiting for a decision on your claim. If the employer or claims administrator will not authorize treatment, use your own health insurance to get medical care. Your health insurer will seek reimbursement from the claims administrator. If you do not have health insurance, there are doctors, clinics or hospitals that will treat you without immediate payment. They will seek reimbursement from the claims administrator.

Switching to a Different Doctor as Your PTP:

- If you are being treated in a Medical Provider Network (MPN), you may switch to other doctors within the MPN after the first visit.
- If you are being treated in a Health Care Organization (HCO), you may switch at least one time to another doctor within the HCO. You may switch to a doctor outside the HCO 90 or 180 days after your injury is reported to your employer (depending on whether you are covered by employer-provided health insurance).
- If you are not being treated in an MPN or HCO and did not predesignate, you may switch to a new doctor one time during the first 30 days after your injury is reported to your employer. Contact the claims administrator to switch doctors. After 30 days, you may switch to a doctor of your choice if

Si Ud. se lesiona o se enferma, ya sea físicamente o mentalmente, debido a su trabajo, incluyendo lesiones que resulten de un crimen en el lugar de trabajo, es posible que Ud. tenga derecho a beneficios de compensación de trabajadores. Utilice el formulario adjunto para presentar un reclamo de compensación de trabajadores con su empleador. **Ud. debe leer toda la información a continuación.** Guarde esta hoja y todos los demás documentos para sus archivos. Es posible que usted reúna los requisitos para todos los beneficios, o parte de éstos, que se enumeran dependiendo de la índole de su reclamo. Si usted presenta un reclamo, l administrador de reclamos, quien es responsable por el manejo de su reclamo, debe notificarle dentro de 14 días si se acepta su reclamo o si se necesita investigación adicional.

Para presentar un reclamo, llene la sección del formulario designada para el "Empleado," guarde una copia, y déle el resto a su empleador. Haga esto de inmediato para evitar problemas con su reclamo. En algunos casos, los beneficios no se iniciarán hasta que usted le informe a su empleador acerca de su lesión mediante la presentación de un formulario de reclamo. Describa su lesión por completo. Incluya cada parte de su cuerpo afectada por la lesión. Si usted le envía por correo el formulario a su empleador, utilice primera clase o correo certificado. Si usted compra un acuse de recibo, usted podrá demostrar que el formulario de reclamo fue enviado por correo y cuando fue entregado. Dentro de un día laboral después de presentar el formulario de reclamo, su empleador debe completar la sección designada para el "Empleador," le dará a Ud. una copia fechada, guardará una copia, y enviará una al administrador de reclamos.

Atención Médica: Su administrador de reclamos pagará por toda la atención médica razonable y necesaria para su lesión o enfermedad relacionada con el trabajo. Los beneficios médicos están sujetos a la aprobación y pueden incluir tratamiento por parte de un médico, los servicios de hospital, la terapia física, los análisis de laboratorio, las medicinas, equipos y gastos de viaje. Su administrador de reclamos pagará directamente los costos de los servicios médicos aprobados de manera que usted nunca verá una factura. Hay límites en terapia quiropráctica, física y otras visitas de terapia ocupacional.

El Médico Primario que le Atiende *(Primary Treating Physician- PTP)* es el médico con la responsabilidad total para tratar su lesión o enfermedad.

- Si usted designó previamente a su médico personal o a un grupo médico, usted podrá ver a su médico personal o grupo médico después de lesionarse.
- Si su empleador está utilizando una red de proveedores médicos (*Medical Provider Network- MPN)* o una Organización de Cuidado Médico *(Health Care Organization- HCO)*, en la mayoría de los casos, usted será tratado en la *MPN* o *HCO* a menos que usted hizo una designación previa de su médico personal o grupo médico. Una *MPN* es un grupo de proveedores de asistencia médica quien da tratamiento a los trabajadores lesionados en el trabajo. Usted debe recibir información de su empleador si su tratamiento es cubierto por una *HCO* o una *MPN*. Hable con su empleador para más información.
- Si su empleador no está utilizando una *MPN* o *HCO*, en la mayoría de los casos, el administrador de reclamos puede elegir el médico que lo atiende primero a menos de que usted hizo una designación previa de su médico personal o grupo médico.
- Si su empleador no ha colocado un cartel describiendo sus derechos para la compensación de trabajadores, Ud. puede ser tratado por su médico personal inmediatamente después de lesionarse.

Dentro de un día laboral después de que Ud. Presente un formulario de reclamo, su empleador o el administrador de reclamos debe autorizar hasta $10000 en tratamiento para su lesión, de acuerdo con las pautas de tratamiento aplicables, hasta que el reclamo sea aceptado o rechazado. Si el empleador o administrador de reclamos no autoriza el tratamiento de inmediato, hable con su supervisor, alguien más en la gerencia, o con el administrador de reclamos. Pida que el tratamiento sea autorizado ya mismo, mientras espera una decisión sobre su reclamo. Si el empleador o administrador de reclamos no autoriza el tratamiento, utilice su propio seguro médico para recibir atención médica. Su compañía de seguro médico buscará reembolso del administrador de reclamos. Si usted no tiene seguro médico, hay médicos, clínicas u hospitales que lo tratarán sin pago inmediato. Ellos buscarán reembolso del administrador de reclamos.

Cambiando a otro Médico Primario o *PTP*:

- Si usted está recibiendo tratamiento en una Red de Proveedores Médicos

your employer or the claims administrator has not created or selected an MPN.

Disclosure of Medical Records: After you make a claim for workers' compensation benefits, your medical records will not have the same level of privacy that you usually expect. If you don't agree to voluntarily release medical records, a workers' compensation judge may decide what records will be released. If you request privacy, the judge may "seal" (keep private) certain medical records.

Problems with Medical Care and Medical Reports: At some point during your claim, you might disagree with your PTP about what treatment is necessary. If this happens, you can switch to other doctors as described above. If you cannot reach agreement with another doctor, the steps to take depend on whether you are receiving care in an MPN, HCO, or neither. For more information, see "Learn More About Workers' Compensation," below.

If the claims administrator denies treatment recommended by your PTP, you may request independent medical review (IMR) using the request form included with the claims administrator's written decision to deny treatment. The IMR process is similar to the group health IMR process, and takes approximately 40 (or fewer) days to arrive at a determination so that appropriate treatment can be given. Your attorney or your physician may assist you in the IMR process. IMR is not available to resolve disputes over matters other than the medical necessity of a particular treatment requested by your physician.

If you disagree with your PTP on matters other than treatment, such as the cause of your injury or how severe the injury is, you can switch to other doctors as described above. If you cannot reach agreement with another doctor, notify the claims administrator in writing as soon as possible. In some cases, you risk losing the right to challenge your PTP's opinion unless you do this promptly. If you do not have an attorney, the claims administrator must send you instructions on how to be seen by a doctor called a qualified medical evaluator (QME) to help resolve the dispute. If you have an attorney, the claims administrator may try to reach agreement with your attorney on a doctor called an agreed medical evaluator (AME). If the claims administrator disagrees with your PTP on matters other than treatment, the claims administrator can require you to be seen by a QME or AME.

Payment for Temporary Disability (Lost Wages): If you can't work while you are recovering from a job injury or illness, you may receive temporary disability payments for a limited period. These payments may change or stop when your doctor says you are able to return to work. These benefits are tax-free. Temporary disability payments are two-thirds of your average weekly pay, within minimums and maximums set by state law. Payments are not made for the first three days you are off the job unless you are hospitalized overnight or cannot work for more than 14 days.

Stay at Work or Return to Work: Being injured does not mean you must stop working. If you can continue working, you should. If not, it is important to go back to work with your current employer as soon as you are medically able. Studies show that the longer you are off work, the harder it is to get back to your original job and wages. While you are recovering, your PTP, your employer (supervisors or others in management), the claims administrator, and your attorney (if you have one) will work with you to decide how you will stay at work or return to work and what work you will do. Actively communicate with your PTP, your employer, and the claims administrator about the work you did before you were injured, your medical condition and the kinds of work you can do now, and the kinds of work that your employer could make available to you.

Payment for Permanent Disability: If a doctor says you have not recovered completely from your injury and you will always be limited in the work you can do, you may receive additional payments. The amount will depend on the type of injury, extent of impairment, your age, occupation, date of injury, and your wages before you were injured.

Supplemental Job Displacement Benefit (SJDB): If you were injured on or after 1/1/04, and your injury results in a permanent disability and your employer does not offer regular, modified, or alternative work, you may qualify for a nontransferable voucher payable for retraining and/or skill enhancement. If you qualify, the claims administrator will pay the costs up to the maximum set by state law.

Death Benefits: If the injury or illness causes death, payments may be made to a

(Medical Provider Network- MPN), usted puede cambiar a otros médicos dentro de la MPN después de la primera visita.

- Si usted está recibiendo tratamiento en un Organización de Cuidado Médico (Healthcare Organization- HCO), es posible cambiar al menos una vez a otro médico dentro de la HCO. Usted puede cambiar a un médico fuera de la HCO 90 o 180 días después de que su lesión es reportada a su empleador (dependiendo de si usted está cubierto por un seguro médico proporcionado por su empleador).
- Si usted no está recibiendo tratamiento en una MPN o HCO y no hizo una designación previa, usted puede cambiar a un nuevo médico una vez durante los primeros 30 días después de que su lesión es reportada a su empleador. Póngase en contacto con el administrador de reclamos para cambiar de médico. Después de 30 días, puede cambiar a un médico de su elección si su empleador o el administrador de reclamos no ha creado o seleccionado una MPN.

Divulgación de Expedientes Médicos: Después de que Ud. presente un reclamo para beneficios de compensación de trabajadores, sus expedientes médicos no tendrán el mismo nivel de privacidad que usted normalmente espera. Si Ud. no está de acuerdo en divulgar voluntariamente los expedientes médicos, un juez de compensación de trabajadores posiblemente decida qué expedientes serán revelados. Si usted solicita privacidad, es posible que el juez "selle" (mantenga privados) ciertos expedientes médicos.

Problemas con la Atención Médica y los Informes Médicos: En algún momento durante su reclamo, podría estar en desacuerdo con su *PTP* sobre qué tratamiento es necesario. Si esto sucede, usted puede cambiar a otros médicos como se describe anteriormente. Si no puede llegar a un acuerdo con otro médico, los pasos a seguir dependen de si usted está recibiendo atención en una *MPN*, *HCO* o ninguna de las dos. Para más información, consulte la sección "Aprenda Más Sobre la Compensación de Trabajadores," a continuación.

Si el administrador de reclamos niega el tratamiento recomendado por su *PTP*, puede solicitar una revisión médica independiente *(Independent Medical Review-IMR)*, utilizando el formulario de solicitud que se incluye con la decisión por escrito del administrador de reclamos negando el tratamiento. El proceso de la *IMR* es parecido al proceso de la *IMR* de un seguro médico colectivo, y tarda aproximadamente 40 (o menos) días para llegar a una determinación de manera que se pueda dar un tratamiento apropiado. Su abogado o su médico le pueden ayudar en el proceso de la *IMR*. La *IMR* no está disponible para resolver disputas sobre cuestiones aparte de la necesidad médica de un tratamiento particular solicitado por su médico.

Si no está de acuerdo con su *PTP* en cuestiones aparte del tratamiento, como la causa de su lesión o la gravedad de la lesión, usted puede cambiar a otros médicos como se describe anteriormente. Si no puede llegar a un acuerdo con otro médico, notifique al administrador de reclamos por escrito tan pronto como sea posible. En algunos casos, usted arriesg perder el derecho a objetar a la opinión de su *PTP* a menos que hace esto de inmediato. Si usted no tiene un abogado, el administrador de reclamos debe enviarle instrucciones para ser evaluado por un médico llamado un evaluador médico calificado *(Qualified Medical Evaluator-QME)* para ayudar a resolver la disputa. Si usted tiene un abogado, el administrador de reclamos puede tratar de llegar a un acuerdo con su abogado sobre un médico llamado un evaluador médico acordado *(Agreed Medical Evaluator- AME)*. Si el administrador de reclamos no está de acuerdo con su *PTP* sobre asuntos aparte del tratamiento, el administrador de reclamos puede exigirle que sea atendido por un *QME* o *AME*.

Pago por Incapacidad Temporal (Sueldos Perdidos): Si Ud. no puede trabajar, mientras se está recuperando de una lesión o enfermedad relacionada con el trabajo, Ud. puede recibir pagos por incapacidad temporal por un periodo limitado. Estos pagos pueden cambiar o parar cuando su médico diga que Ud. está en condiciones de regresar a trabajar. Estos beneficios son libres de impuestos. Los pagos por incapacidad temporal son dos tercios de su pago semanal promedio, con cantidades mínimas y máximas establecidas por las leyes estales. Los pagos no se hacen durante los primeros tres días en que Ud. no trabaje, a menos que Ud. sea hospitalizado una noche o no puede trabajar durante más de 14 días.

Permanezca en el Trabajo o Regreso al Trabajo: Estar lesionado no significa que usted debe dejar de trabajar. Si usted puede seguir trabajando, usted debe hacerlo. Si no es así, es importante regresar a trabajar con su empleador actual tan

spouse and other relatives or household members who were financially dependent on the deceased worker.

It is illegal for your employer to punish or fire you for having a job injury or illness, for filing a claim, or testifying in another person's workers' compensation case (Labor Code 132a). If proven, you may receive lost wages, job reinstatement, increased benefits, and costs and expenses up to limits set by the state.

Resolving Problems or Disputes: You have the right to disagree with decisions affecting your claim. If you have a disagreement, contact your employer or claims administrator first to see if you can resolve it. If you are not receiving benefits, you may be able to get State Disability Insurance (SDI) or unemployment insurance (UI) benefits. Call the state Employment Development Department at (800) 480-3287 or (866) 333-4606, or go to their website at www.edd.ca.gov.

You Can Contact an Information & Assistance (I&A) Officer: State I&A officers answer questions, help injured workers, provide forms, and help resolve problems. Some I&A officers hold workshops for injured workers. To obtain important information about the workers' compensation claims process and your rights and obligations, go to www.dwc.ca.gov or contact an I&A officer of the state Division of Workers' Compensation. You can also hear recorded information and a list of local I&A offices by calling (800) 736-7401.

You can consult with an attorney. Most attorneys offer one free consultation. If you decide to hire an attorney, his or her fee will be taken out of some of your benefits. For names of workers' compensation attorneys, call the State Bar of California at (415) 538-2120 or go to their website at **www. californiaspecialist.org**.

Learn More About Workers' Compensation: For more information about the workers' compensation claims process, go to www.dwc.ca.gov. At the website, you can access a useful booklet, "Workers' Compensation in California: A Guidebook for Injured Workers." You can also contact an Information & Assistance Officer (above), or hear recorded information by calling 1-800-736-7401.

pronto como usted pueda medicamente hacerlo. Los estudios demuestran que entre más tiempo esté fuera del trabajo, más difícil es regresar a su trabajo original y a sus salarios. Mientras se está recuperando, su *PTP*, su empleador (supervisores u otras personas en la gerencia), el administrador de reclamos, y su abogado (si tiene uno) trabajarán con usted para decidir cómo va a permanecer en el trabajo o regresar al trabajo y qué trabajo hará. Comuníquese de manera activa con su *PTP*, su empleador y el administrador de reclamos sobre el trabajo que hizo antes de lesionarse, su condición médica y los tipos de trabajo que usted puede hacer ahora y los tipos de trabajo que su empleador podría poner a su disposición.

Pago por Incapacidad Permanente: Si un médico dice que no se ha recuperado completamente de su lesión y siempre será limitado en el trabajo que puede hacer, es posible que Ud. reciba pagos adicionales. La cantidad dependerá de la clase de lesión, grado de deterioro, su edad, ocupación, fecha de la lesión y sus salarios antes de lesionarse.

Beneficio Suplementario por Desplazamiento de Trabajo *(Supplemental Job Displacement Benefit- SJDB)*: Si Ud. se lesionó en o después del 1/1/04, y su lesión resulta en una incapacidad permanente y su empleador no ofrece un trabajo regular, modificado, o alternativo, usted podría cumplir los requisitos para recibir un vale no-transferible pagadero a una escuela para recibir un nuevo un curso de reentrenamiento y/o mejorar su habilidad. Si Ud. cumple los requisios, el administrador de reclamos pagará los gastos hasta un máximo establecido por las leyes estatales.

Beneficios por Muerte: Si la lesión o enfermedad causa la muerte, es posible que los pagos se hagan a un cónyuge y otros parientes o a las personas que viven en el hogar que dependían económicamente del trabajador difunto.

Es ilegal que su empleador le castigue o despida por sufrir una lesión o enfermedad laboral, por presentar un reclamo o por testificar en el caso de compensación de trabajadores de otra persona. (Código Laboral, sección 132a.) De ser probado, usted puede recibir pagos por pérdida de sueldos, reposición del trabajo, aumento de beneficios y gastos hasta los límites establecidos por el estado.

Resolviendo problemas o disputas: Ud. tiene derecho a no estar de acuerdo con las decisiones que afecten su reclamo. Si Ud. tiene un desacuerdo, primero comuníquese con su empleador o administrador de reclamos para ver si usted puede resolverlo. Si usted no está recibiendo beneficios, es posible que Ud. pueda obtener beneficios del Seguro Estatalde Incapacidad *(State Disability Insurance- SDI)* o beneficios del desempleo *(Unemployment Insurance- UI)*. Llame al Departamento del Desarrollo del Empleo estatal al (800) 480-3287 o (866) 333-4606, o visite su página Web en www.edd.ca.gov.

Puede Contactar a un Oficial de Información y Asistencia *(Information & Assistance- I&A)*: Los Oficiales de Información y Asistencia *(I&A)* estatal contestan preguntas, ayudan a los trabajadores lesionados, proporcionan formularios y ayudan a resolver problemas. Algunos oficiales de *I&A* tienen talleres para trabajadores lesionados. Para obtener información importante sobre el proceso de la compensación de trabajadores y sus derechos y obligaciones, vaya a www.dwc.ca.gov o comuníquese con un oficial de información y asistencia de la División Estatal de Compensación de Trabajadores. También puede escuchar información grabada y una lista de las oficinas de *I&A* locales llamando al (800) 736-7401.

Ud. puede consultar con un abogado. La mayoría de los abogados ofrecen una consulta gratis. Si Ud. decide contratar a un abogado, los honorarios serán tomados de algunos de sus beneficios. Para obtener nombres de abogados de compensación de trabajadores, llame a la Asociación Estatal de Abogados de California *(State Bar)* al (415) 538-2120, o consulte su página Web en www.californiaspecialist.org.

Aprenda Más Sobre la Compensación de Trabajadores: Para obtener más información sobre el proceso de reclamos del programa de compensación de trabajadores, vaya a www.dwc.ca.gov. En la página Web, podrá acceder a un folleto útil, "Compensación del Trabajador de California: Una Guía para Trabajadores Lesionados." También puede contactar a un oficial de Información y Asistencia (arriba), o escuchar información grabada llamando al 1-800-736-7401.

State of California
Department of Industrial Relations
DIVISION OF WORKERS' COMPENSATION

WORKERS' COMPENSATION CLAIM FORM (DWC 1)

Employee: Complete the **"Employee"** section and give the form to your employer. Keep a copy and mark it "**Employee's Temporary Receipt"** until you receive the signed and dated copy from your employer. You may call the Division of Workers' Compensation and hear recorded information at **(800) 736-7401.** An explanation of workers' compensation benefits is included in the Notice of Potential Eligibility, which is the cover sheet of this form. Detach and save this notice for future reference.

You should also have received a pamphlet from your employer describing workers' compensation benefits and the procedures to obtain them. You may receive written notices from your employer or its claims administrator about your claim. If your claims administrator offers to send you notices electronically, and you agree to receive these notices only by email, please provide your email address below and check the appropriate box. If you later decide you want to receive the notices by mail, you must inform your employer in writing.

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

Estado de California
Departamento de Relaciones Industriales
DIVISION DE COMPENSACIÓN AL TRABAJADOR

PETITION DEL EMPLEADO PARA DE COMPENSACIÓN DEL TRABAJADOR (DWC 1)

Empleado: *Complete la sección* ***"Empleado"*** *y entregue la forma a su empleador. Quédese con la copia designada* ***"Recibo Temporal del Empleado"*** *hasta que Ud. reciba la copia firmada y fechada de su empleador. Ud. puede llamar a la Division de Compensación al Trabajador al* ***(800) 736-7401*** *para oir información gravada. Una explicación de los beneficios de compensación de trabajadores está incluido en la Notificación de Posible Elegibilidad, que es la hoja de portada de esta forma. Separe y guarde esta notificación como referencia para el futuro.*

Ud. también debería haber recibido de su empleador un folleto describiendo los benficios de compensación al trabajador lesionado y los procedimientos para obtenerlos. Es posible que reciba notificaciones escritas de su empleador o de su administrador de reclamos sobre su reclamo. Si su administrador de reclamos ofrece enviarle notificaciones electrónicamente, y usted acepta recibir estas notificaciones solo por correo electrónico, por favor proporcione su dirección de correo electrónico abajo y marque la caja apropiada. Si usted decide después que quiere recibir las notificaciones por correo, usted debe de informar a su empleador por escrito.

Toda aquella persona que a propósito haga o cause que se produzca cualquier declaración o representación material falsa o fraudulenta con el fin de obtener o negar beneficios o pagos de compensación a trabajadores lesionados es culpable de un crimen mayor "felonia".

Employee—complete this section and see note above ***Empleado—complete esta sección y note la notación arriba.***

1. Name. *Nombre.* ______________________ Today's Date. *Fecha de Hoy.* ______________________
2. Home Address. *Dirección Residencial.* ______________________
3. City. *Ciudad.* ______________ State. *Estado.* ______________ Zip. *Código Postal.* ______________
4. Date of Injury. *Fecha de la lesión (accidente).* ______________ Time of Injury. *Hora en que ocurrió.* ________a.m. ________p.m.
5. Address and description of where injury happened. *Dirección/lugar dónde occurió el accidente.* ______________________
6. Describe injury and part of body affected. *Describa la lesión y parte del cuerpo afectada.* ______________________
7. Social Security Number. *Número de Seguro Social del Empleado.* ______________________
8. ☐ Check if you agree to receive notices about your claim by email only. ☐ *Marque si usted acepta recibir notificaciones sobre su reclamo solo por correo electrónico.* Employee's e-mail. ______________ *Correo electrónico del empleado*. ______________.
You will receive benefit notices by regular mail if you do not choose, or your claims administrator does not offer, an electronic service option. *Usted recibirá notificaciones de beneficios por correo ordinario si usted no escoge, o su administrador de reclamos no le ofrece, una opción de servicio electrónico.*
9. Signature of employee. *Firma del empleado.* ______________________

Employer—complete this section and see note below. ***Empleador—complete esta sección y note la notación abajo.***

10. Name of employer. *Nombre del empleador.* ______________________
11. Address. *Dirección.* ______________________
12. Date employer first knew of injury. *Fecha en que el empleador supo por primera vez de la lesión o accidente.* ______________
13. Date claim form was provided to employee. *Fecha en que se le entregó al empleado la petición.* ______________
14. Date employer received claim form. *Fecha en que el empleado devolvió la petición al empleador.*______________
15. Name and address of insurance carrier or adjusting agency. *Nombre y dirección de la compañía de seguros o agencia adminstradora de seguros*. ______________
16. Insurance Policy Number. *El número de la póliza de Seguro.*______________
17. Signature of employer representative. *Firma del representante del empleador.* ______________
18. Title. *Título.* ______________ 19. Telephone. *Teléfono.* ______________

Employer: You are required to date this form and provide copies to your insurer or claims administrator and to the employee, dependent or representative who filed the claim within **one working day** of receipt of the form from the employee.

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

Empleador: *Se requiere que Ud. feche esta forma y que provéa copias a su compañía de seguros, administrador de reclamos, o dependiente/representante de reclamos y al empleado que hayan presentado esta petición dentro del plazo de* ***un día hábil*** *desde el momento de haber sido recibida la forma del empleado.*

EL FIRMAR ESTA FORMA NO SIGNIFICA ADMISION DE RESPONSABILIDAD

☐Employer copy/*Copia del Empleador* ☐Employee copy/*Copia del Empleado* ☐Claims Administrator/*Administrador de Reclamos* ☐Temporary Receipt/*Recibo del Empleado*

Rev. 1/1/2016

SAMPLE INCIDENT REPORT

☐ Declined Medical Treatment ☐ Requested/Received Medical Treatment

EMPLOYEE PORTION

Employee Name:	**Job Title:**	**Department:**	**Employee #:**

Home Address:	**Phone Number:**

Date of Birth:	**Gender:** ☐ Male ☐ Female	**Date of Hire:**	**Shift, Work Days, Hours Per Day:**	**Shift Start Time:** am/pm
Incident Date:	**Incident Time:** am/pm	**Location of Incident:**		

Date Reported:	**Reported To (Name, Job Title):**	**Date Claim Form Provided:**

Incident Classification: (select all that apply) ☐ Fall ☐ Lifting ☐ Exposure ☐ Caught In/Between ☐ Trip/Slip ☐ Struck by object ☐ Bite/sting ☐ Training ☐ Vehicle accident, with injury ☐ Vehicle accident, no injury ☐ Cut, puncture, scrape ☐ Other

Body Part Injured (e.g., right wrist, left knee, etc.):	**How Injury Occurred** (struck by…, fell from…, etc.)**:**

Was safety equipment provided? ☐ No ☐ Yes ☐ DNA	**Was safety equipment utilized?** ☐ No ☐ Yes ☐ DNA	**Equipment/materials Employee was using when incident occurred:**

Did Employee leave shift to go home? ☐ No ☐ Yes	**Unable to work for at least one full day?** ☐ No ☐ Yes	**Date last worked:**	**Date returned to work:**	**Still off work?** ☐ No ☐ Yes

Were other Employees injured? ☐ No ☐ Yes If yes, name(s):	**Were there witnesses to the incident?** ☐ No ☐ Yes If yes, name(s):

Describe any <u>previous</u> conditions/injuries to body part currently injured:

Employee Statement of Incident. This section should be filled out by the Employee and include as much detail as possible, such as activity being performed, objects carried, equipment used, hazardous conditions, etc. Attach additional sheets if necessary:

Recommendation on how to prevent this accident from recurring:

Please check one:

☐ I understand that I **<u>am not</u>** filing a Workers' Compensation claim at this time. I choose not to complete the Form DWC-1, "Employee's Claim for Workers' Compensation Benefits" at this time. If I am in need of medical treatment in the future related to this incident, I will immediately inform my Supervisor and complete the Form DWC-1.

☐ I understand that I **<u>am</u>** filing a Workers' Compensation claim at this time. I am also aware that I must also immediately inform my Supervisor and complete the Form DWC-1.

Employee Acknowledgement: The above information is true and correct to the best of my knowledge.

Employee's Signature:	**Date:**

SUPERVISOR'S PORTION

Medical Treatment: ☐ Employee requires/requests medical treatment from a physician.
☐ Employee declined medical treatment or only received minor First Aid care. (Please complete page 2)

Do you agree with the Employee Statement of Incident?	☐ No	☐ Yes
Could the injury have been prevented?	☐ No	☐ Yes
If yes, has corrective action been taken or Employee been counseled on prevention of further occurrence?	☐ No	☐ Yes
Was employee trained in the appropriate use of Personal Protective Equipment/Proper safety procedures?	☐ No	☐ Yes
Was employee cautioned for failure to use Personal Protective Equipment/Proper safety procedures?	☐ No	☐ Yes
Had any safety hazards that contributed to this incident been previously reported?	☐ No	☐ Yes
Did employee promptly report the injury/illness?	☐ No	☐ Yes

Please indicate what contributed to the injury or illness (check all that apply):

☐ Improper instruction	☐ Unsafe arrangement or process	☐ Lack of training or skill	☐ Unsafe position or posture
☐ Poor ventilation	☐ Operating without authority	☐ Improper dress	☐ Distraction/Horseplay
☐ Improper maintenance	☐ Physical or mental impairment	☐ Unsafe/defective equipment	☐ Unguarded hazard
☐ Improper use of equipment	☐ Improper lifting technique	☐ Failure to wear/improper use of protective equipment	
☐ Inoperative safety device	☐ Poor housekeeping	☐ Other ____________________	

Supervisor comments regarding incident (*<u>Required</u>*):

Supervisor Name:	**Title:**	**Telephone:**

Signature:	**Date:**

SAMPLE DECLINATION OF MEDICAL TREATMENT

This form should be completed ONLY if the Employee DECLINES medical treatment. If the Employee visits their pre-designated physician or the City's designated medical facility the "Employee's Claim for Workers' Compensation Benefits" (Form DWC-1) must also be completed.

EMPLOYEE: Check all that apply.

- ☐ In my opinion, I am not in need of any medical treatment at this time

OR

In my opinion, I have received sufficient First Aid care in the form of:

- ☐ Application of antiseptics
- ☐ Treatment of first-degree burn(s)
- ☐ Application of bandage(s)
- ☐ Use of elastic bandage(s)
- ☐ Removal of foreign bodies not embedded in eye (only irrigation required)
- ☐ Removal of foreign bodies from wound (uncomplicated procedure, for example, using tweezers)
- ☐ Use of nonprescription medications
- ☐ Application of hot or cold compress(es)
- ☐ Application of ointments to abrasions to prevent drying or cracking

I am fully capable of performing my Usual and Customary position. At this time, I decline medical care. If I need medical care related to this incident in the future, I will notify my Supervisor immediately and complete the Form DWC-1.

Employee Name: ______________________________ Job Title: ______________________________

Employee Signature: ______________________________ Date: ______________________________

SUPERVISOR:

Supervisor Name: ______________________________ Job Title: ______________________________

Supervisor Signature: ______________________________ Date: ______________________________

Note: California Labor Code Section 5401(a) defines a First Aid injury as "any one-time treatment, and any follow-up visit for the purpose of observation of minor scratches, cuts, burns, splinters, or other minor industrial injury, which does not ordinarily require medical care" and states that any injury that "results in lost time beyond the employee's work shift at the time of injury or which results in medical treatment beyond first aid" must be filed as a claim. All of the treatments detailed above fall under the First Aid category; therefore, unless further treatment is necessary, a workers' compensation claim does not need to be filed.

SCORE MEMBER PARTICIPATION FY 24/25

City of Biggs
City Of Colfax
City Of Dunsmuir
City Of Etna
City Of Isleton
City Of Live Oak
Town Of Loomis
City Of Loyalton
City Of Montague
City Of Mount Shasta
City Of Portola
City Of Rio Dell
City Of Shasta Lake
City Of Susanville
City Of Tulelake
City Of Weed
City Of Yreka

Alliant Insurance Services
560 Mission Street, 6th Floor
San Francisco, CA 94105

Policy Period	Services Performed By:	Services Performed For:
July 1, 2024 – June 30, 2025	McLaren's Global Claims Services 18100 Von Karman Ave 11th Floor Irvine, CA 92612	Small Cities Organized Risk Effort 2180 Harvard Street STE 460 Sacramento, CA 95815

APIP Property Claims Contacts

i	***Alliant Insurance Services, Inc.*** ***560 Mission Street, 6th Floor, San Francisco, CA 94105*** ***Toll Free Voice: (877) 725-7695 Fax: (415) 403-1466***
i	***Robert A. Frey — RPA, Senior Vice President, Regional Claims Director*** ***560 Mission Street, 6th Floor, San Francisco, CA 94105Phone: 415-403-1445*** ***Cell: 415-518-8490 Email: rfrey@alliant.com***
i	***Diana Walizada — AIC, CPIW, RPA, AINS Vice President, Claims Unit Manager*** ***560 Mission Street, 6th Floor, San Francisco, CA 94105*** ***Phone: 415-403-1453 Email: dwalizada@alliant.com***
i	***Sandra Doig — McLaren's Global Claims Services*** ***18100 Von Karman Avenue 11th Floor, Irvine, CA 92612*** ***Phone: 949-757-1413 Email: sandra.doig@mclarens.com***
i	***Marcus Beverly — First Vice President, CPCU, AIC, ARM-P*** ***2180 Harvard Street STE 460, Sacramento, CA 95815*** ***Phone: 916-643-2704 Email: Marcus.Beverly@alliant.com***
i	***Michelle Minnick — Account Manager*** ***2180 Harvard Street STE 460, Sacramento, CA 95815*** ***Phone: 916-643-2715 Email: Michelle.Minnick@alliant.com***

Client Responsibilities for Reporting Claims

During regular business hours (between 8:30 AM and 5:00 PM PST) First Notice of Claim should be reported to Alliant Insurance Services via telephone, fax, mail or e-mail to our San Francisco Office. Include all persons above on any claim communication. Please include the Insured /JPA name along with the following information when reporting claims:

- Time, date and specific location of property damaged
- A description of the incident that caused the damage (such as fire, theft or water damage)
- Estimated amount of loss in dollars
- Contact person for claim including name, title, voice & fax numbers
- Complete and return the Property Loss Notice for processing.
- Mortgagee or Loss Payee name, address, and account number

LOSS NOTIFICATION REQUIREMENT

ALLIANT PROPERTY INSURANCE PROGRAM (APIP)

Claim notifications need to be sent to Robert Frey, Diana Walizada and Sandra Doig. In the event this is a *Cyber* loss please include item III contact, for a *Pollution* loss please include item IV contact in addition to Alliant Insurance Services contacts.

I. During regular business hours (between 8:30 AM and 5:00 PM PST), First Notice of Claim should be reported to Alliant Insurance Services via telephone, fax, mail or e-mail to our San Francisco Office:

Robert A. Frey, RPA
Senior Vice President,
Regional Claims Director
Voice: (415) 403-1445
Email: **rfrey@alliant.com**

Diana L. Walizada, AIC, CPIW, RPA, AINS
Vice President, Claims Unit Manager
Voice:(415)403-1453
Email: **dwalizada@alliant.com**

Address:
Alliant Insurance Services, Inc.
560 Mission Street, 6th Floor
San Francisco CA 94105
Toll Free Voice: (877) 725-7695 Fax: (415) 403-1466

II. Please be sure to include APIP's Claim Administrator as a CC on all Claims correspondence:

Address:
Sandra Doig
McLaren's Global Claims Services
18100 Von Karman Avenue, 10th Floor
Irvine, CA 92612
Voice: (949) 757-1413 Fax: (949) 757-1692
Email: **sandra.doig@mclarens.com**

III. Cyber Liability Carrier Beazley NY needs to also be provided with Notice of Claim immediately (if purchased):

Address:
Beazley Group
1270 Avenue of the America's, Suite 1200
New York, NY 10020
Fax: (546) 378-4039
Email: **bbr.claims@beazley.com**

Address:
Elaine G. Tizon, V.P. CISR, E-mail: **elaine.tizon@alliant.com**
Donna Peterson, E-mail: **donna.peterson@alliant.com**
560 Mission Street, 6th Floor
San Francisco, CA 94105
Voice: (415) 403-1458 Fax: (415) 403-1466

IV. Pollution Liability Carrier Ironshore Specialty Insurance Company (if purchased):

Address:
Ironshore Environmental Claims CSO
28 Liberty Street, 5th Floor
New York, NY 10005
In emergency call: (888) 292-0249
Fax: (646) 826-6601
Email: **USClaims@ironshore.com**

Address:
Akbar Sharif
Claims Advocate
18100 Von Karman Avenue, 10th Floor
Irvine, CA 92612
Voice: (949) 260-5088 Fax: (415) 403-1466
Email: akbar.sharif@alliant.com

Please include the Insured /JPA name along with the following information when reporting claims:

- Time, date and specific location of property damaged
- A description of the incident that caused the damage (such as fire, theft or water damage)
- Estimated amount of loss in dollars
- Contact person for claim including name, title, voice & fax numbers
- Complete and return the Property Loss Notice for processing.
- Mortgagee or Loss Payee name, address, and account number

Applicable in Arizona

For your protection, Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Applicable in Arkansas, Delaware, District of Columbia, Kentucky, Louisiana, Maine, Michigan, New Jersey, New Mexico, New York, North Dakota, Pennsylvania, South Dakota, Tennessee, Texas, Virginia and West Virginia

Any person who knowingly and with intent to defraud any insurance company or another person, files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact, material thereto, commits a fraudulent insurance act, which is a crime, subject to criminal prosecution and [NY: substantial] civil penalties. In DC, LA, ME, TN and VA, insurance benefits may also be denied.

Applicable in California

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Applicable in Colorado

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Applicable in Florida and Idaho

Any person who Knowingly and with the intent to injure, Defraud, or Deceive any Insurance Company Files a Statement of Claim Containing any False, Incomplete or Misleading information is Guilty of a Felony.*
* In Florida - Third Degree Felony

Applicable in Hawaii

For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

Applicable in Indiana

A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Applicable in Minnesota

A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

Applicable in Nevada

Pursuant to NRS 686A.291, any person who knowingly and willfully files a statement of claim that contains any false, incomplete or misleading information concerning a material fact is guilty of a felony.

Applicable in New Hampshire

Any person who, with purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

Applicable in Ohio

Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Applicable in Oklahoma

WARNING: Any person who knowingly and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

IN THE EVENT OF A

PROPERTY LOSS:

1) Follow your organization procedures for reporting and responding to an incident

2) Alert local emergency authorities, as appropriate

3) Report the incident to Alliant Insurance Services *immediately at:*

877-725-7695

All property losses must be reported as soon as practicable upon knowledge within the risk management or finance division of the insured that a loss has occurred.

Be prepared to give basic information about the location and nature of the incident, as well as steps which have been taken in response to the incident.

4) Report the incident to McLarens Global Claims Services AND your Alliant representative

PROPERTY FIRST NOTICE OF LOSS FORM

SEND TO: Alliant Insurance Services, Inc.
BY MAIL: 560 Mission Street, 6th Floor, San Francisco, CA 94105
BY FAX: (415) 403-1466
BY EMAIL: rfrey@alliant.com AND dwalizada@alliant.com
Carbon Copy APIP Claims Administrator: sandra.doig@mclarens.com and your Alliant representative

Today's Date: ________________

Type of Claim: (check all that apply)

☐ **Real Property** ☐ **Vehicles**

☐ **Personal Property** ☐ **Other**

Insured's Name & Contact Information

Insured's Name:____________________________________ **Point of Contact:**______________________

Address:____

Phone #:_______________________ **Email Address:**____

Broker/Agent's Name & Contact Information

Company Name: **Alliant Insurance Services - Claims** **Point of Contact:** **Robert A. Frey & Diana L. Walizada**

Address: **560 Mission Street, 6th Floor, San Francisco, CA 94105**

Phone #: **877-725-7695** **Fax #:** **415-403-1466**

Policy Information

Policy Number: **APIP2024 (Dec 04)**________________ **Policy Period:** **July 1, 2024-July 1, 2025**

Limits of Liability: ______________**per**__________**agg** **Self-Insured Retention/Deductible:** _____________

Loss Information

Date of Incident/Claim: _____________ **Location:**____

Description of Loss: ____

____

Please list all attached or enclosed documentation: ☐**(check if none provided)** _________________________

____

Name of Person Completing This Form:_______________________**Signature:**______________________

Per the Master Policy Wording, Section IV General Conditions;

L. NOTICE OF LOSS

In the event of loss or damage insured against under this Policy, the Insured shall give notice thereof to ALLIANT INSURANCE SERVICES, INC., 560 Mission Street, 6th Floor, San Francisco, CA 94105. TEL NO. (877) 725-7695, FAX NO. (415) 403-1466 of such loss. Such notice is to be made as soon as practicable after the inception of loss.

SCORE MEMBER PARTICIPATION FY 24/25

City of Biggs
City Of Colfax
City Of Dunsmuir
City Of Etna
City Of Isleton
City Of Live Oak
Town Of Loomis
City Of Loyalton
City Of Montague
City Of Mount Shasta
City Of Portola
City Of Rio Dell
City Of Shasta Lake
City Of Susanville
City Of Tulelake
City Of Weed
City Of Yreka

Alliant Insurance Services

560 Mission Street, 6th Floor
San Francisco, CA 94105

Policy Period	Services Performed By:	Services Performed For:
July 1, 2024 – June 30, 2025	Beazley Group 1270 Avenue of the America's, Suite 1200 New York, NY 10020	Small Cities Organized Risk Effort 2180 Harvard Street STE 460 Sacramento, CA 95815

APIP Cyber Claims Contacts

i	***Beazley Group – address listed above.*** ***Phone: 1-866-567-8570 Email: bbr.claims@beazley.com***
i	***Elaine Tizon — CISR, Assistant Vice President, Claims Advocate*** ***560 Mission Street, 6th Floor, San Francisco, CA 94105*** ***Phone: 415-403-1458 Email: elaine.tizon@alliant.com***
i	***Alliant Insurance Services, Inc.*** ***560 Mission Street, 6th Floor, San Francisco, CA 94105*** ***Toll Free Voice: (877) 725-7695 Fax: (415) 403-1466***
i	***Robert A. Frey — RPA, Senior Vice President, Regional Claims Director*** ***560 Mission Street, 6th Floor, San Francisco, CA 94105*** ***Phone: 415-403-1445 Cell: 415-518-8490 Email: rfrey@alliant.com***
i	***Donna Peterson*** ***560 Mission Street, 6th Floor, San Francisco, CA 94105*** ***Phone: 877-725-7695 Email: Donna.Peterson@alliant.com***
i	***Sandra Doig — McLaren's Global Claims Services*** ***18100 Von Karman Avenue 11th Floor, Irvine, CA 92612*** ***Phone: 949-757-1413 Email: sandra.doig@mclarens.com***

Client Responsibilities for Reporting Claims

During regular business hours (between 8:30 AM and 5:00 PM PST) First Notice of Claim should be reported to Alliant Insurance Services via telephone, fax, mail or e-mail to our San Francisco Office. Cyber Liability Carrier Beazley NY needs to also be provided with Notice of Claim immediately. Include all persons above on any claim communication. Please include the Insured /JPA name along with the following:

- Time, date and specific location of property damaged
- A description of the incident that caused the damage (such as fire, theft or water damage)
- Estimated amount of loss in dollars
- Contact person for claim including name, title, voice & fax numbers
- Complete and return the Property Loss Notice for processing.
- Mortgagee or Loss Payee name, address, and account number

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ALLIANT PROPERTY INSURANCE PROGRAM (APIP)

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Regional Claims Director
Voice: (415) 403-1445
Email: **rfrey@alliant.com**

Diana L. Walizada, AIC, CPIW, RPA, AINS
Vice President, Claims Unit Manager
Voice:(415)403-1453
Email: **dwalizada@alliant.com**

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Alliant Insurance Services, Inc.
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San Francisco CA 94105
Toll Free Voice: (877) 725-7695 Fax: (415) 403-1466

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Beazley Group
1270 Avenue of the America's, Suite 1200
New York, NY 10020
Fax: (546) 378-4039
Email: **bbr.claims@beazley.com**

Address:
Elaine G. Tizon, V.P. CISR, E-mail: **elaine.tizon@alliant.com**
Donna Peterson, E-mail: **donna.peterson@alliant.com**
560 Mission Street, 6th Floor
San Francisco, CA 94105
Voice: (415) 403-1458 Fax: (415) 403-1466

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Address:
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28 Liberty Street, 5th Floor
New York, NY 10005
In emergency call: (888) 292-0249
Fax: (646) 826-6601
Email: **USClaims@ironshore.com**

Address:
Akbar Sharif
Claims Advocate
18100 Von Karman Avenue, 10th Floor
Irvine, CA 92612
Voice: (949) 260-5088 Fax: (415) 403-1466
Email: **akbar.sharif@alliant.com**

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A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Applicable in Minnesota

A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

Applicable in Nevada

Pursuant to NRS 686A.291, any person who knowingly and willfully files a statement of claim that contains any false, incomplete or misleading information concerning a material fact is guilty of a felony.

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Applicable in Ohio

Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Applicable in Oklahoma

WARNING: Any person who knowingly and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

IN THE EVENT OF A

CYBER LOSS:

1) *Follow your organizations procedures for reporting and responding to an incident*

2) *Alert authorities, as appropriate*

3) *Report the incident to* Beazley Group *immediately at:*

bbr.claims@beazley.com

(866)567-8570

All Cyber losses must be reported as soon as practicable upon knowledge by the insured that a loss has occurred.

Be prepared to give basic information about the location and nature of the incident, as well as steps which have been taken in response to the incident.

4) *Report the incident to Alliant Claims Department and your Alliant representative*

SPECIAL NOTE REGARDING PRIVACY NOTIFICATION COSTS:

The policy provides a $500,000 Aggregate Limit for Privacy Notification Costs. If you utilize a Beazley vendor, the limit is increased to $1,000,000.

Please contact Beazley for a list of approved vendors.

CYBER FIRST NOTICE OF LOSS FORM

SEND TO: **Beazley Group**

BY MAIL: 1270 Avenue of the America's, Suite 1200, New York, NY 10020

BY FAX: (546) 378-4039

BY EMAIL: bbr.claims@beazley.com

CC Alliant Claims Department:
elaine.tizon@alliant.com, Donna.Peterson@alliant.com **and your Alliant representative**

Today's Date: ______________

Insured's Name & Contact Information

Insured's Name:_______________________________________ **Point of Contact:**________________________

Address:____

Phone #:_________________________ **Email Address:**____

Broker/Agent's Name & Contact Information

Company Name: Alliant Insurance Services – Claims **Point of Contact:** Elaine Tizon

Address: 560 Mission Street, 6th Floor, San Francisco, CA 94105

Phone #: 877-725-7695 Fax #:415-403-1466

Policy Information

Policy Number:____________________ **Policy Period:** July 1, 2024-July 1, 2025

Limits of Liability:_______________per_______________agg **Self-Insured Retention/Deductible**____________

Loss Information

Date of Incident/Claim:_____________ **Location:**____

Description of Loss:____

____

Please list all attached or enclosed documentation: ☐**(check if none provided)**________________________

____

Name of Person Completing This Form:_________________________**Signature:**________________________

SCORE MEMBER PARTICIPATION FY 24/25

City of Biggs
City Of Colfax
City Of Dunsmuir
City Of Etna
City Of Isleton
City Of Live Oak
Town Of Loomis
City Of Loyalton
City Of Montague
City Of Mount Shasta
City Of Portola
City Of Rio Dell
City Of Shasta Lake
City Of Susanville
City Of Tulelake
City Of Weed
City Of Yreka

Ironshore Environmental Claims CSO

28 Liberty Street, 5th Floor
New York, NY 10005

Policy Period	Services Performed By:	Services Performed For:
July 1, 2024 – June 30, 2025	Ironshore Environmental Claims CSO 28 Liberty Street, 5th Floor New York, NY 10005	Small Cities Organized Risk Effort 2180 Harvard Street STE 460 Sacramento, CA 95815

APIP Pollution Claims Contacts

Ironshore Environmental Claims CSO - address listed above.
Environmental Emergency: 888-292-0249 Fax: 646-826-6601
Email: USClaims@ironshore.com

Akbar Sharif — Claims Advocate
18100 Von Karman Avenue 11th Floor, Irvine, CA 92612
Phone: 949-260-5088 Email: asharif@alliant.com

Alliant Insurance Services, Inc.
560 Mission Street, 6th Floor, San Francisco, CA 94105
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Diana Walizada — AIC, CPIW, RPA, AINS Vice President, Claims Unit Manager
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Phone: 415-403-1453 Email: dwalizada@alliant.com

Sandra Doig — McLaren's Global Claims Services
18100 Von Karman Avenue 11th Floor, Irvine, CA 92612
Phone: 949-757-1413 Email: sandra.doig@mclarens.com

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LOSS NOTIFICATION REQUIREMENT
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Email: **bbr.claims@beazley.com**

Address:
Elaine G. Tizon, V.P. CISR, E-mail: **elaine.tizon@alliant.com**
Donna Peterson, E-mail: **donna.peterson@alliant.com**
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Email: **USClaims@ironshore.com**

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Claims Advocate
18100 Von Karman Avenue, 10th Floor
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Voice: (949) 260-5088 Fax: (415) 403-1466
Email: akbar.sharif@alliant.com

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POLLUTION LIABILITY

IN THE EVENT OF AN

ENVIRONMENTAL EMERGENCY:

1) ***Follow your organization procedures for reporting and responding to an incident***

2) ***Alert local emergency authorities, as appropriate***

3) ***Report the incident immediately at:***

888-292-0249

4] *Report the incident to Alliant*

Akbar Sharif
Claims Advocate
949-260-5088
415-403-1466 – fax
akbar.sharif@alliant.com

Be prepared to give basic information about the location and nature of the incident, as well as steps which have been taken in response to the incident.

DO follow your organization’s detailed response plan
DO contact your management as well as appropriate authorities
DO ensure anyone who could come in contact with a spill or release is kept away

DO NOT ignore a potential spill or leak
DO NOT attempt to respond beyond your level of training or certification

SEND TO: IRONSHORE ENVIRONMENTAL CLAIMS CSO
BY MAIL: 28 Liberty Street, 5th Floor, New York, NY 10005
BY PHONE: (888) 292-0249
BY FAX: (646) 826-6601
BY EMAIL: USClaims@ironshore.com
CC Alliant Insurance: akbar.sharif@alliant.com and your Alliant Representative

Today's Date: ___________________

Notice of: (check all that apply)

☐ Pollution Incident ☐ Potential Claim ☐ Other ___________________
☐ Third-Party Claim ☐ Litigation Initiated

Insured's Name & Contact Information

Company Name:_________________________________ Point of Contact:_________________________________

Address:____

Phone #:__________________________ Email Address:____

Broker/Agent's Name & Contact Information

Company Name:_____Alliant Insurance Services - Claims Point of Contact:_____Akbar Sharif___

Address:___18100 Von Karman Ave., 10th Floor, Irvine, CA 92612______________________________

Phone #:___949-260-5088___________________

Policy Information

Policy Number: Policy Period: July 1, 2024-July 1, 2025

Limits of Liability: ______________per____________ agg. Self-Insured Retention/Deductible____________

Loss Information

Date of Incident/Claim:_____________ Location:____

Claimant Name/Address:____

Description of Loss:____

____

Please list all attached or enclosed documentation: ☐(check if none provided)________________________

____

Name of Person Completing This Form:_________________________Signature:_________________________

SCORE MEMBER PARTICIPATION FY 24/25

City of Biggs
City Of Colfax
City Of Dunsmuir
City Of Live Oak
Town Of Loomis
City Of Loyalton
City Of Montague
City Of Mount Shasta
City Of Portola
City Of Rio Dell
City Of Shasta Lake
City Of Susanville
City Of Tulelake
City Of Weed
City Of Yreka

Ironshore Specialty Insurance Company

c/o Ironshore Insurance Services, INC.
28 Liberty Street, 5th Floor
New York, NY 10005

Policy Period	Services Performed By:	Services Performed For:
July 1, 2024 – June 30, 2025	Ironshore Insurance Services, INC. 28 Liberty Street, 5th Floor New York, NY 10005	Small Cities Organized Risk Effort 2180 Harvard Street STE 460 Sacramento, CA 95815

PRISM Pollution Claims Contacts

Ironshore Specialty Insurance Company
28 Liberty Street, 5th Floor New York, NY 10005
Phone: 888-292-0249 Fax: 646-826-6601
Email: USClaims@ironshore.com

Akbar Sharif — Claims Advocate
18100 Von Karman Avenue 11th Floor, Irvine, CA 92612
Phone: 949-260-5088 Email: asharif@alliant.com

Alliant Insurance Services, Inc.
560 Mission Street, 6th Floor, San Francisco, CA 941051
Toll Free Voice: (877) 725-7695 Fax: (415) 403-1466

Robert A. Frey — RPA, Senior Vice President, Regional Claims Director
560 Mission Street, 6th Floor, San Francisco, CA 94105
Phone: 415-403-1445 Email: rfrey@alliant.com

Diana Walizada — AIC, CPIW, RPA, AINS Vice President, Claims Unit Manager
560 Mission Street, 6th Floor, San Francisco, CA 94105
Phone: 415-403-1453 Email: dwalizada@alliant.com

Sandra Doig — McLaren's Global Claims Services
18100 Von Karman Avenue 11th Floor, Irvine, CA 92612
Phone: 949-757-1413 Email: sandra.doig@mclarens.com

Client Responsibilities for Reporting Claims

- Follow your entity's procedures for reporting and responding to an incident
- Alert local emergency authorities, as appropriate
- Report the incident to your Alliant Representative (see list above)
  - Report the incident to Ironshore Specialty Insurance Company immediately at 1-888-292-0249. "Notice of Claim reporting" means any "notice of claim/circumstance", "notice of loss", "notice of wrongful act", or other such reference in the policy designated for the reporting of claims, loss, acts, occurrences or situations that may give rise or result in loss under this policy.

All Pollution incidents must be reported immediately upon discovery.

SCORE MEMBER PARTICIPATION FY 24/25

City of Biggs
City Of Colfax
City Of Dunsmuir
City Of Live Oak
Town Of Loomis
City Of Loyalton
City Of Montague
City Of Mount Shasta
City Of Rio Dell
City Of Shasta Lake
City of Susanville
City Of Weed
City Of Yreka

AIG

Financial Lines Claims
PO Box 25947
Shawnee Mission, KS 66225

Policy Period	Services Performed By:	Services Performed For:
July 1, 2024 – June 30, 2025	AIG-Financial Lines Claims PO Box 25947 Shawnee Mission, KS 66225	Small Cities Organized Risk Effort 2180 Harvard Street STE 460 Sacramento, CA 95815

ALLIANT CRIME (ACIP) CLAIMS CONTACTS

i	***AIG — Financial Lines Claims*** ***PO Box 25947, Shawnee Mission, KS 66225*** ***Phone: 888-602-5246 Fax: 866-227-1750 Email: c-claim@aig.com***
i	***Robert A. Frey — RPA, Senior Vice President, Regional Claims Director*** ***560 Mission Street, 6th Floor, San Francisco, CA 94105*** ***Phone: 415-403-1445 Email: rfrey@alliant.com***
i	***Diana Walizada — AIC, CPIW, RPA, AINS Vice President, Claims Unit Manager*** ***560 Mission Street, 6th Floor, San Francisco, CA 94105*** ***Phone: 415-403-1453 Email: dwalizada@alliant.com***
i	***Sandra Doig — McLaren's Global Claims Services*** ***18100 Von Karman Avenue 11th Floor, Irvine, CA 92612*** ***Phone: 949-757-1413 Email: sandra.doig@mclarens.com***

CLIENT RESPONSIBILITIES FOR REPORTING CLAIMS

- Claims can be reported to AIG via regular mail to:
  AIG, Financial lines Claims
  PO Box 25947
  Shawnee Mission, KS 66225

  - Claims may also be reported by email to: ***c-claim@aig.com***
    *NOTE: Your email must reference the policy number for this policy 13090202
- Please be sure to forward a copy of the notice to:
  Alliant Insurance Services, Inc.
  ATTN: Robert Frey
  100 Pine Street, 11th Floor
  San Francisco, CA 94111
  Phone: 415-403-1400
  Fax: 415-403-1466

SCORE MEMBER PARTICIPATION FY 24/25

City of Biggs
City Of Colfax
City Of Dunsmuir
City Of Live Oak
Town Of Loomis
City Of Mount Shasta
City Of Portola
City Of Rio Dell
City Of Shasta Lake
City Of Susanville
City Of Tulelake
City Of Weed
City Of Yreka

ERMA

Employment Practice Liability Claims
1750 Creekside Oaks Drive STE 200
Sacramento, CA 95833

Policy Period	**Services Performed By:**	**Services Performed For:**
July 1, 2024 – June 30, 2025	ERMA EPL Claims 1750 Creekside Oaks Dre STE 200 Sacramento, CA 95833	Small Cities Organized Risk Effort 2180 Harvard Street STE 460 Sacramento, CA 95815

ERMA Employment Practice Liability Claims Contacts

i	***Stacey Sullivan — ERMA Litigation Manager*** ***Phone: 916-244-1125 Email: stacey.sullivan@sedgwick.com***
i	***Julia Byrd — ERMA Litigation Analyst*** ***Phone: 916-290-4627 Email: julia.byrd@sedgwick.com***
i	***Randy Lingenfelter — Liability Claims Supervisor*** ***Phone: 916-389-2622 Email: randy.lingenfelter@georgehills.com***
i	***Dana Calkins — Senior Liability Adjuster*** ***Phone: 916-333-0575 Email: dana.calkins@georgehills.com***
i	***Kathleen Proctor — Client Services Manager*** ***Phone: 916-467-8126 Email: Kathlen.proctor@georgehills.com***
i	***Marcus Beverly — First Vice President, CPCU, AIC, ARM-P*** ***2180 Harvard Street STE 460, Sacramento, CA 95815*** ***Phone: 916-643-2704 Email: Marcus.Beverly@alliant.com***
i	***Michelle Minnick — Account Manager*** ***2180 Harvard Street STE 460, Sacramento, CA 95815*** ***Phone: 916-643-2715 Email: Michelle.Minnick@alliant.com***

Client Responsibilities for Reporting Claims

- Members are required to notify ERMA **within 30 days upon receipt of notice of a Claim** by completing the Employment Risk Management Authority (ERMA) initial Report Form (see next page) and submitting to:
  Stacey Sullivan — ERMA Litigation Manager
  Email: stacey.sullivan@sedgwick.com
  Julia Byrd — ERMA Litigation Analyst
  Email: julia.byrd@sedgwick.com
  Please attach a copy of all Governmental Tort Claim, DFEH and/or EEOC documents you have regarding this claim or occurrence.

- Please be sure to forward a copy of the notice to Alliant Staff as well as George Hills at: *MyGHCNewClaims@georgehills.com* **with the following information in the subject line: "SCORE - NEW EPL CLAIM – CITY NAME"**
  Kathleen Proctor, Unit Manager 916-467-8126

EMPLOYMENT RISK MANAGEMENT AUTHORITY (ERMA)

INITIAL REPORT FORM

In order to assist ERMA in monitoring claims and maintaining reserves, please fill out the following form for each claim or occurrence that is required to be reported to ERMA. Please answer each item as completely as possible with the information available to you. Use additional sheets as necessary. **Please attach to this form a copy of all Governmental Tort Claim, CRD, and/or EEOC, and internal or external complaint/investigation documents you have regarding this claim or occurrence.** Assignments to defense counsel will be made through ERMA after consultation with the ERMA member. If you have any questions, please call Stacey Sullivan at (916) 244 – 1125.

1. Name of organization:
2. Name(s) of claimant:
3. Claimant's job title:
4. What is the claimant's employment status (current/terminated/paid or unpaid leave/suspended)?

   If terminated, on leave, or suspended, please include date:
5. Claimant's yearly salary: $
6. Claimant's date of hire:
7. Complaint submitted? ☐ YES ☐ NO

   If **written**, please provide date of complaint and attach a copy.

   If **verbal**, please provide date and name/title of the person the complaint was reported to.
8. CRD complaint filed? ☐ YES ☐ NO
   If yes, date of filing:
   Date of CRD Right to Sue Letter (if received):
9. EEOC complaint filed? ☐ YES ☐ NO
   If yes, date of filing:
   Date of EEOC Right to Sue Letter (if received):
10. Governmental tort claim filed? ☐ YES ☐ NO
    If yes, date of filing:
    Date and form of response to tort claim:
11. Date of first incident underlying the complaint:
12. Brief factual summary:
13. Demand – if provided by claimant:

EMPLOYMENT RISK MANAGEMENT AUTHORITY
(ERMA)

INITIAL REPORTING REQUIREMENTS

Pursuant to ERMA's Memorandum of Coverage effective July 1, 2008, all ERMA members are required to notify ERMA within 30 days upon receipt of notice of a *Claim.* Written notice containing particulars sufficient to identify the claimant(s), the *Covered Party(ies),* and also reasonably obtainable information with respect to the circumstances of the *Claim*, as well as the names and addresses of the *Covered Party(ies)* and of available witnesses, shall be given to ERMA or any of its authorized agents as soon as possible. The form opposite this notice should be used to report claims to ERMA.

In addition to the above, if a suit is brought against a *Covered Party(ies)*, the *Covered Party(ies)* is also obligated to forward immediately to ERMA every demand, notice, summons, or other process received by it or its representative.

If you have any questions regarding reporting to ERMA, please call Stacey Sullivan at (916) 244 – 1125.

Please email this completed form along with all supporting documentation to:

Stacey Sullivan, ERMA Litigation Manager
stacey.sullivan@sedgwick.com

SCORE MEMBER PARTICIPATION FY 24/25

City of Biggs
City Of Colfax
City Of Dunsmuir
City Of Etna
City Of Isleton
City Of Live Oak
Town Of Loomis
City Of Loyalton
City Of Montague
City Of Mount Shasta
City Of Portola
City Of Rio Dell
City Of Shasta Lake
City Of Susanville
City Of Tulelake
City Of Weed
City Of Yreka

Travelers
401 Lennon Lane
Walnut Creek, CA 94598

Policy Period	Services Performed By:	Services Performed For:
July 1, 2024 – June 30, 2025	Travelers Bond & Specialty Insurance Department	Small Cities Organized Risk Effort 2180 Harvard Street STE 460 Sacramento, CA 95815

Crime – Identity Fraud Claims Contacts

i	***Travelers Bond & Financial Products Claim Department*** ***Phone: 800-842-8496 Email: BSICLAIMS@travelers.com***
i	***Marcus Beverly — First Vice President, CPCU, AIC, ARM-P*** ***2180 Harvard Street STE 460, Sacramento, CA 95815*** ***Phone: 916-643-2704 Email: Marcus.Beverly@alliant.com***
i	***Michelle Minnick — Account Manager*** ***2180 Harvard Street STE 460, Sacramento, CA 95815*** ***Phone: 916-643-2715 Email: Michelle.Minnick@alliant.com***

Client Responsibilities for Reporting Claims

i	▸ To file a claim under the Master Policy (#106526214) please contact: **Travelers Bond & Financial Products Claim Department** **Phone: 800-842-8496** **Email: *BSICLAIMS@travelers.com***

Identity Fraud Expense Reimbursement Coverage and Identity Fraud Resolution Services

SMALL CITIES ORGANIZED RISK EFFORT (SCORE) has purchased the Identity Fraud Expense Master policy from Travelers Bond & Financial Products in order to provide you with this valuable coverage.

Your Policy Number is: 106526214

Your Coverage Limit is: $25,000

Your Deductible is: $0

If you are a victim of Identity Fraud, please call Travelers to report your claim and begin the Identity Fraud Resolution Process: 800.842.8496

The coverage reimburses identity fraud victims for the following:

- Lost wages as a result of time taken off from work to deal with the fraud, including wrongful incarceration – up to $1000 per week for a maximum period of five weeks
- Notary and certified mail charges for completing and delivering fraud affidavits
- Fees to re-apply for loans that were denied as a result of erroneous credit information due to the identity fraud
- Long distance telephone charges for calling merchants, law enforcement agencies or credit grantors to discuss an actual identity fraud
- Attorney fees incurred, with Travelers Bond & Financial Product's prior consent, for:
  - Defending suits brought incorrectly by merchants or their collection agencies
  - Removing criminal or civil judgments wrongly entered against the victim
  - Challenging information in a credit report
  - Release of medical records in cases of medical identity fraud
  - Contesting wrongfully incurred tax liability
  - Contesting the wrongful transfer of ownership of an insured person's tangible property
- Additional coverage for spouse, family, and daycare and eldercare coverage are available by endorsement
- Costs for daycare and eldercare coverage, if that coverage is necessary for an insured person to attend meetings or otherwise have the ability to restore financial health and credit history as a result of identity fraud
- Travel and accommodations expense up to $1,000 per week up to five weeks
- Expenses and fees for new government issued identification such as passports, drivers license and social security cards
- Expense and fees for copies of health records for purpose of investigating medical identity fraud

Identity Fraud Resolution Services

The services are provided by an experienced fraud resolution team who works closely with victims to learn about the incident, document the case, advise on case resolution, and support victims by providing written correspondence that will help expedite resolution of their situation.

The fraud resolution team performs the following activities:

- Obtains a 3-in-1 credit report to review with the victim
- Documents event and contact history with the victim
- At the victim's request, assists the victim in placing fraud alerts with major credit reporting agencies
- Provides contact information for all future calls
- Completes dispute letters on behalf of the victim for approval and signing
- Enrolls the victim in six months of daily credit monitoring
- Provides the victim with a Fraud First Aid Kit which includes:
  - Tips for fraud victims
  - Credit reporting agency information
  - Contact history tracking template
  - Pre-populated letters to creditors

Becoming a victim of identity fraud is a frightening, frustrating experience. It can happen to anyone at any time. Our identity fraud specialists can help victims during this difficult time. Not only will we pay for expenses associated with clearing up your credit, but we will also provide you with detailed information on how to fix your credit and resolve other identity fraud issues.

[1]Source: www.idsafety.net/report.html

Travelers Casualty and Surety Company of America and its property casualty affiliates
One Tower Square
Hartford, CT 06183

travelers.com

This material does not amend, or otherwise affect, the provisions or coverages of any insurance policy or bond issued by Travelers. It is not a representation that coverage does or does not exist for any particular claim or loss under any such policy or bond. Coverage depends on the facts and circumstances involved in the claim or loss, all applicable policy or bond provisions, and any applicable law. Availability of coverage referenced in this document can depend on underwriting qualifications and state regulations.

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Travelers is pleased to supply this member benefit card template which you may reproduce and distribute to members at your option.

TRAVELERS

SMALL CITIES ORGANIZED RISK EFFORT (SCORE) has purchased the Identity Fraud Expense Master policy from Travelers Bond & Financial Products in order to provide you with this valuable coverage.

Your Policy Number is: 106526214

Your Coverage Limit is: $25,000

Your Deductible is: $0

If you are a victim of Identity Fraud, please call Travelers to report your claim and begin the Identity Fraud Resolution Process: 800.842.8496

TRAVELERS

SMALL CITIES ORGANIZED RISK EFFORT (SCORE) has purchased the Identity Fraud Expense Master policy from Travelers Bond & Financial Products in order to provide you with this valuable coverage.

Your Policy Number is: 106526214

Your Coverage Limit is: $25,000

Your Deductible is: $0

If you are a victim of Identity Fraud, please call Travelers to report your claim and begin the Identity Fraud Resolution Process: 800.842.8496

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Your Deductible is: $0

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Your Policy Number is: 106526214

Your Coverage Limit is: $25,000

Your Deductible is: $0

If you are a victim of Identity Fraud, please call Travelers to report your claim and begin the Identity Fraud Resolution Process: 800.842.8496

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SMALL CITIES ORGANIZED RISK EFFORT (SCORE) has purchased the Identity Fraud Expense Master policy from Travelers Bond & Financial Products in order to provide you with this valuable coverage.

Your Policy Number is: 106526214

Your Coverage Limit is: $25,000

Your Deductible is: $0

If you are a victim of Identity Fraud, please call Travelers to report your claim and begin the Identity Fraud Resolution Process: 800.842.8496

SCORE MEMBER PARTICIPATION FY 24/25

City of Biggs
City Of Colfax
City Of Dunsmuir
City Of Etna
City Of Isleton
City Of Live Oak
Town Of Loomis
City Of Loyalton
City Of Montague
City Of Mount Shasta
City Of Portola
City Of Rio Dell
City Of Shasta Lake
City Of Susanville
City Of Tulelake
City Of Weed
City Of Yreka

Underwriters at Lloyd's of London

One Lime Street
London
EC3M 7HA
England

Policy Period	Services Performed By:	Services Performed For:
July 1, 2024 – June 30, 2025	Alliant Insurance Services 701 B. Street, 6th Floor San Diego, CA 92101-8156	Small Cities Organized Risk Effort 2180 Harvard Street STE 460 Sacramento, CA 95815

ALLIANT DEADLY WEAPONS RESPONSE – CLAIMS CONTACTS

i	***Beazley 24-hour/7-day Telephone number*** ***Phone: 860-677-3790 Email: DWPclaims@beazley.com***
i	***Marcus Beverly — First Vice President, CPCU, AIC, ARM-P*** ***2180 Harvard Street STE 460, Sacramento, CA 95815*** ***Phone: 916-643-2704 Email: Marcus.Beverly@alliant.com***
i	***Michelle Minnick — Account Manager*** ***2180 Harvard Street STE 460, Sacramento, CA 95815*** ***Phone: 916-643-2715 Email: Michelle.Minnick@alliant.com***
	Crisis Services Provided by CrisisRisk: ***https://www.crisisrisk.com***

CLIENT RESPONSIBILITIES FOR REPORTING CLAIMS

- If a Deadly Weapon Event occurs or is believed to have occurred You shall, as soon as reasonably practicable, but in no case more than forty-eight (48) hours after you become aware of a deadly weapon event, call Beazley's 24-hour/7-day Telephone Number: 860-677-3790 to notify the event responder as shown in the declarations. Immediate notification to the event responder will be deemed notification of the incident under this Policy.
- Any claim, or any circumstance which could reasonably be expected to give rise to a claim, shall be considered to be reported to us when notice is first given to **DWPclaims@Beazley.com**.

In the unlikely event that there is no response on the 24-hour Crisis Management Response Team telephone number contact either of the following additional representatives as soon as possible

William Clarke (New York) Tel: +1 (646) 943-5900
Alex Hill (London) Tel: +44 (20) 7667 7326
Email: **DWPclaims@beazley.com**

SCORE MEMBER PARTICIPATION FY 24/25

City Of Colfax
City Of Dunsmuir
City Of Etna
Town Of Loomis
City Of Loyalton
City Of Mount Shasta
City Of Portola
City Of Susanville
City Of Tulelake
City Of Weed
City Of Yreka

Allianz Global Corporate
One Progress Point Parkway, 2nd Floor
O'Fallon, MO 63368

Policy Period	Services Performed By:	Services Performed For:
July 1, 2024 – June 30, 2025	Allianz Global Corporate & Specialty	Small Cities Organized Risk Effort 2180 Harvard Street STE 460 Sacramento, CA 95815

ALLIANT MOBILE VEHICLE PROGRAM CLAIMS CONTACTS

i	***Allianz Global Corporate & Specialty*** ***Phone: 800-558-1606 Fax: 888-323-6450*** ***Email: NewLoss@agcs.allianz.com***
i	***Elaine Tizon – Claims Advocate Lead*** ***Phone: 415-403-1458*** ***Email: Elaine.Tizon@alliant.com***
i	***Marcus Beverly — First Vice President, CPCU, AIC, ARM-P*** ***2180 Harvard Street STE 460, Sacramento, CA 95815*** ***Phone: 916-643-2704 Email: Marcus.Beverly@alliant.com***
i	***Michelle Minnick — Account Manager*** ***2180 Harvard Street STE 460, Sacramento, CA 95815*** ***Phone: 916-643-2715 Email: Michelle.Minnick@alliant.com***

CLIENT RESPONSIBILITIES FOR REPORTING CLAIMS

- To file a claim please notify Allianz of a new claim via telephone, mail or email. We encourage you to email notice with a copy to your Alliant broker representative and contact listed below:
  Allianz Global Corporate & Specialty
  Attn: FNOL Claims Unit
  One Progress Point Parkway, 2nd Floor O'Fallon, MO 63368
  Phone: 800-558-1606 Fax: 888-323-6450
  Email: NewLoss@agcs.allianz.com

  Please include the following information as part of your claim notice and have it available for our claims advocate:

  Contact information:
  Policy #: MXI 93058679
  Date of loss:
  Vehicle Number/Description:
  Description of loss:

Alliant Motor Vehicle Program (AMVP) Claim Reporting Instructions

Report To: Allianz Global Corporate & Specialty Insurance Company

Allianz highly skilled Marine Claims professionals are committed to providing you, our valued client, with an unparalleled level of service excellence and responsiveness to any claim situation that you may have.

You can notify Allianz of a new claim via any of the following reporting options. We encourage you to *email notice with a copy to your Alliant broker representative and contact below*.

Email: NewLoss@agcs.allianz.com

Telephone: **800.558.1606**

Fax: **888.323.6450**

Mailing Address: Allianz Global Corporate & Specialty
Attn: FNOL Claims Unit
One Progress Point Parkway, 2nd FL
O'Fallon, MO 63368

Please also **email a copy of the first notice of loss to:**

Elaine.Tizon@alliant.com,
Elaine Tizon, Claims Advocate Lead,
Alliant Insurance Services, Inc.
Tel: 415.403.1458

Please include the following information as part of your claim notice and have it available for our claims advocate:

Contact information: ____

Policy #: MXI 93058679

Date of loss: ______________________________

Vehicle Number/Description: ______________________________

Description of loss: ____

A Public Service Agency

REPORT OF TRAFFIC ACCIDENT OCCURRING IN CALIFORNIA

Please type or print.

# OF VEHICLES	DATE OF ACCIDENT	ACCIDENT LOCATION (*CITY/COUNTY*) (***CALIFORNIA ONLY***)	ON PRIVATE PROPERTY ☐ Yes ☐ No

REPORTING PARTY'S INFORMATION

TIME OF ACCIDENT Hour ______ ☐ AM ☐ PM | ☐ Moving ☐ Stopped in Traffic ☐ Parked ☐ Pedestrian ☐ Bicyclist ☐ Other (*E.G., ROLLAWAY*) | DRIVING FOR EMPLOYER ☐ Yes ☐ No

DRIVER'S NAME (*FIRST, MIDDLE, LAST*)	DRIVER LICENSE NUMBER	STATE
DRIVER'S STREET ADDRESS		DATE OF BIRTH
CITY / STATE / ZIP CODE	TELEPHONE NUMBERS Wk ( ) Hm ( )	
VEHICLE (*YEAR AND MAKE*) / VEHICLE LICENSE PLATE OR VEHICLE IDENTIFICATION NUMBER	STATE	DAMAGES OVER $1,000 ☐ Yes ☐ No
VEHICLE OWNER (*PERSON OR COMPANY*)		DATE OF BIRTH
ADDRESS / CITY	STATE	ZIP CODE
INSURANCE COMPANY NAME *(NOT AGENT OR BROKER)* AT THE TIME OF THE ACCIDENT	POLICY NUMBER	
COMPANY NAIC NUMBER / POLICY PERIOD From: ______ To: ______	POLICY HOLDER NAME	

OTHER PARTY'S INFORMATION

☐ Moving ☐ Stopped in Traffic ☐ Parked ☐ Pedestrian ☐ Bicyclist ☐ Other (*E.G., ROLLAWAY*) | DRIVING FOR EMPLOYER ☐ Yes ☐ No

DRIVER'S NAME (*FIRST, MIDDLE, LAST*)	DRIVER LICENSE NUMBER	STATE
DRIVER'S STREET ADDRESS		DATE OF BIRTH
CITY / STATE / ZIP CODE	TELEPHONE NUMBERS Wk ( ) Hm ( )	
VEHICLE (*YEAR AND MAKE*) / VEHICLE LICENSE PLATE OR VEHICLE IDENTIFICATION NUMBER	STATE	DAMAGES OVER $1,000 ☐ Yes ☐ No
VEHICLE OWNER (*PERSON OR COMPANY*)		DATE OF BIRTH
ADDRESS / CITY	STATE	ZIP CODE
INSURANCE COMPANY NAME *(NOT AGENT OR BROKER)* AT THE TIME OF THE ACCIDENT	POLICY NUMBER	
COMPANY NAIC NUMBER / POLICY PERIOD From: ______ To: ______	POLICY HOLDER NAME	

INJURY/DEATH PROPERTY DAMAGE

NAME AND ADDRESS OF INDIVIDUAL INJURED OR DECEASED	☐ Injured ☐ Deceased	☐ Driver ☐ Passenger ☐ Bicyclist ☐ Pedestrian
NAME AND ADDRESS OF INDIVIDUAL INJURED OR DECEASED	☐ Injured ☐ Deceased	☐ Driver ☐ Passenger ☐ Bicyclist ☐ Pedestrian
OTHER PROPERTY DAMAGED (*TELEPHONE POLES, FENCE, LIVESTOCK, ETC.*)		DAMAGES OVER $1,000 ☐ Yes ☐ No
PROPERTY OWNER'S NAME AND ADDRESS		

READ IMPORTANT INFORMATION ON BACK

I certify (or declare) under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

DATE	PRINTED NAME	SIGNATURE X

☐ ADDITIONAL INFORMATION ATTACHED

A YOUR VEHICLE **CALIFORNIA INSURANCE INFORMATION** **DO NOT DETACH**

The Department may send this part to the **insurance company** indicated. If not **fully completed**, it will be assumed you were **not** insured for the accident and **your license will be suspended.**

DMV FILE NUMBER

INSURANCE

NAME OF INSURANCE COMPANY (*NOT AGENT OR BROKER*) THAT ISSUED THE LIABILITY POLICY COVERING THE OPERATION OF YOUR VEHICLE			
POLICY NUMBER	POLICY PERIOD From: ______ To: ______	DRIVER LICENSE NUMBER (*DRIVER OF YOUR VEHICLE*)	
DATE OF ACCIDENT	IN OR NEAR (*CITY OR TOWN*) (***CALIFORNIA ONLY***)		
VEHICLE (*YEAR AND MAKE*)	VEHICLE IDENTIFICATION NUMBER	VEHICLE LICENSE PLATE NUMBER	STATE
DRIVER	ADDRESS		
OWNER	ADDRESS		
FULL NAME OF POLICY HOLDER	ADDRESS		

SR 1A (REV. 1/2017) **WWW**

If the policy was not in effect, this form must be completed and returned to DMV within 20 days.

The undersigned company advises that with respect to the reported accident, the policy reported on the reverse side:

☐ **WAS NOT** IN EFFECT

☐ Was not a liability policy ☐ Did not cover the vehicle/driver ☐ Number is not a company policy number

Policy Number ______________________ Policy Period from ______________ to ______________

Signature ______________________

Title ______________________

Date ______________________

MAIL TO:
Department of Motor Vehicles
P.O. Box 942884
Sacramento, CA 94284-0884

IMPORTANT INFORMATION

California law requires *traffic accidents* on a California street/highway or private property to be reported to the Department of Motor Vehicles (DMV) within 10 days if there was an injury, death *or* property damage in excess of $1,000. Untimely reporting could result in DMV suspending a driver license. Accidents involving vehicles *not required to be registered* such as an off-road vehicle (OHV), implement of husbandry, or snowmobile **or** occurring on a military base **or** occurring on the driver's *own* property involving *only* the personal property of the driver *and* there was no injury or death are not reportable.

The law requires the driver to file **this SR 1 form** with DMV **regardless of fault**. This report must be made in addition to any other report filed with a law enforcement agency, insurance company, or the California Highway Patrol (CHP) as their reports **do not** satisfy the filing requirement. An insurance agent, attorney, or other designated representative may file the report for the driver.

The law requires every driver and every owner of a motor vehicle to be "financially responsible" for any injury or damage resulting from operating or owning a motor vehicle. The minimum insurance level for "financial responsibility" is **public liability and property damage coverage** of $15,000 for injury or death of one person, $30,000 for injury or death of two or more persons and $5,000 property damage per accident. Comprehensive and collision insurance **does not meet the legal requirement.**

The *California Vehicle Code* (CVC) §1806 requires DMV to record accident information **regardless of fault** when individuals report accidents under the Financial Responsibility Law or if law enforcement agencies or CHP investigate and make a report.

WHEN COMPLETING THIS FORM...

Please print within the spaces and boxes on this form. If you need to provide additional information on a separate piece of paper(s) or you include a *copy* of any law enforcement agency report, please check the box to indicate 'Additional Information Attached'. **If you are the passenger reporting the accident**, be sure to identify yourself by using the 'other' box and stating 'passenger' in the explanation.

- Write **unk (for unknown)** or **none** in any space or box when you do not have information on the other party involved.
- Give insurance information that is complete and which *correctly* and *fully* identifies the **company** that *issued* the policy.
- Place the correct National Association of Insurance Commissioners (NAIC) number for your insurance company in the boxes provided. The NAIC number should be located on your insurance ID card or you can contact your insurance agent or company for the information.
- Identify any person involved in the accident (driver, passenger, bicyclist, pedestrian, etc.) who you saw was injured *or* complained of bodily injury or know to be deceased.
- Record in the OTHER PROPERTY DAMAGED section any damage to telephone poles, fences, street signs, guard posts, trees, livestock, dogs, etc., meeting the filing requirement, including amount. T*his may require that you contact the owner of the property for an estimate of damages.*
- Once you have completed this report, please mail it to:

Department of Motor Vehicles
Financial Responsibility
Mail Station J237
P.O. Box 942884
Sacramento, CA 94284-0884

DMV does not accept reports or take actions against non-reporting or uninsured motorists unless this SR 1 form is sent to DMV by someone involved in the accident or their designee and the report is received by DMV *within one calendar year of the accident date.*

ADVISORY STATEMENT

The accident information on the SR 1 is required under the authority of Divisions 6 and 7 of the CVC. Failure to provide the information will result in suspension of the driving privilege. Except as made confidential by law (e.g., medical information) or exempted under the Public Records Act, the information is a public record, is regularly used by law enforcement agencies and insurance companies, and is open to public inspection. CVC §16005 limits the public record for SR 1 reports to accident involvement, but does allow persons with a proper interest (involved drivers, their employers, etc.) to receive specified information. Individuals may inspect or obtain copies of information contained in their records during regular office hours. The Financial Responsibility Unit Manager, 2570 24th Street, Sacramento, CA 95818 (telephone number: 916-657-6677) is responsible for maintaining this information.

SCORE Program Administration Contact Information

CONOR BOUGHEY FIRST VICE PRESIDENT

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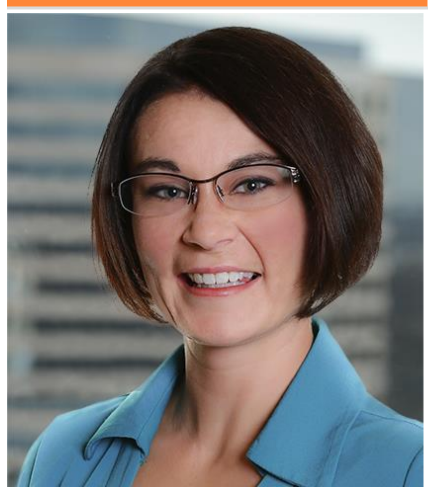
MICHELLE MINNICK ACCOUNT MANAGER



Tel 916-643-2715
Fax 916-643-2750
Michelle.Minnick@alliant.com

Company Information

Alliant Insurance Services, Inc.
2180 Harvard Street,
Suite 460
Sacramento, California 95815

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Fax (916) 643-2750

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Corporate License No. 0C36861

SCORE FY 24/25 CLAIMS REPORTING MANUAL