



SEE REVERSE SIDE FOR INSTRUCTIONS

PLEASE PRINT OR TYPE

NAME: \_\_\_\_\_ SOCIAL SECURITY NUMBER: \_\_\_\_\_

MAILING ADDRESS: \_\_\_\_\_ FILE NUMBER: \_\_\_\_\_

1. TITLE: \_\_\_\_\_ 2. SCHOOL/OFFICE: \_\_\_\_\_

3. SCHOOL/OFFICE ADDRESS: \_\_\_\_\_

4. DATE OF ASSAULT: \_\_\_\_\_ 5. NATURE OF INJURY: \_\_\_\_\_

6. DESCRIPTION OF ASSAULT: (If additional space is needed write on separate sheet and attach to claim)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

7. WERE YOU ABSENT DUE TO INJURY? YES  NO  : If yes, see paragraph 1c of instructions.

8. CHECK HEALTH PLAN CURRENTLY ENROLLED IN AND CHOICE OF OPTIONAL BENEFITS RIDER:

HEALTH PLAN	NO OPTIONAL RIDER	OPTIONAL RIDER	UFT OPTIONAL RIDER
a. <input type="checkbox"/> HIP/HMO	<input type="checkbox"/>	<input type="checkbox"/>	
b. <input type="checkbox"/> MED-PLAN	<input type="checkbox"/>	<input type="checkbox"/>	
c. <input type="checkbox"/> GHI-CBP	<input type="checkbox"/>	<input type="checkbox"/>	
d. <input type="checkbox"/> GHI-TYPE C	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

9. Are you or your spouse enrolled in any Private or Group Health Insurance Plans which provide coverage for any expenses incurred other than in section 8 above? YES  NO  If yes, please provide the following:

9a. Name of carrier \_\_\_\_\_

Carrier address \_\_\_\_\_

Policy holder \_\_\_\_\_ Policy number \_\_\_\_\_

9b. Name of carrier \_\_\_\_\_

Carrier address \_\_\_\_\_

Policy holder \_\_\_\_\_ Policy number \_\_\_\_\_

10. MEDICAL EXPENSES: \$ \_\_\_\_\_ (see § 1a of Instructions)

11. REIMBURSEMENTS: \$ \_\_\_\_\_ (see § 1e of Instructions)

Subtract item 11 from item 10.  
Remainder is entered in item 12.

12. AMOUNT CLAIMED: \$ \_\_\_\_\_

13. I hereby submit a claim for medical expenses as a result of an assault sustained in the line-of-duty. The facts in connection with the injuries are indicated above. This claim is made by me and submitted to the Board of Education with the intent that the Board of Education rely thereon in approving and paying my claim.

SIGNATURE OF CLAIMANT

DATE

14. CERTIFICATE BY PRINCIPAL OR HEAD OF BUREAU

I hereby transmit herewith a claim submitted by \_\_\_\_\_  
to the best of my knowledge, information and belief, the facts contained under paragraphs 1 through 7 are substantially true.

SIGNATURE AND TITLE

DATE

PRINT NAME

MAKE NO ENTRY BELOW THIS LINE (For Medical Bureau-Claims Unit use only)

Date Approved \_\_\_\_\_ For Claims Unit: \_\_\_\_\_

Amount \$ \_\_\_\_\_

Date Disapproved \_\_\_\_\_