CRUM & FORSTER
EST. 1822
A FAIRFAX COMPANY
ADMINISTERED BY BLUE STAR CLAIMS LLC

BLUE STAR
BLUE STAR CLAIMS LLC

Dear Crum & Forster Insurance Company Customer,

We are so happy that you have selected United States Fire Insurance Company for your Occupational Accident program. These claims are administered by Blue Star Claims LLC and we hope to make the claims process hassle free.

Our goal is to provide service unsurpassed in the claims management arena. We want to assist the Independent Contractor so it is a positive experience.

We pride ourselves in utilizing preferred provider networks, monitoring medical care for the best outcomes and providing disability management when a contractor is taken off work.

Taking care of the Independent Contractor is job one. We know that it is important for them to get back to work. Please let us know how we can assist to make your program successful.

To start the claim process, you may direct the Independent Contractor to complete the initial claim form paperwork on our website at www.bluestarclaims.com.

If the Independent Contractor needs to utilize our preferred clinics for care, we are filed under: Self Employed BSC.

Please let us know if you have any questions or need anything further.

Sincerely,

Jason Shultz

Jason Shultz
Vice President of Operations

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REPORT A CLAIM

Our mission at Blue Star Claims LLC is to always provide prompt and excellent customer service for the independent contractors and contract companies.

BLUE STAR CLAIMS OFFERS YOU OPTIONS ON REPORTING NEW CLAIMS:

WEB:
WWW.BLUESTARCLAIMS.COM

PHONE:
(480) 579-2501
*For interpreter services, please call iLingo2 at (800) 311-8331 for assistance in reporting claims

FAX:
(480) 579-2476

EMAIL:
INTAKE@BLUESTARCLAIMS.COM

MAIL:
BLUE STAR CLAIMS LLC
21001 N. TATUM BLVD, SUITE 1630-646
PHOENIX, AZ 85050

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OCCUPATIONAL ACCIDENT PROGRAM FOR INDEPENDENT CONTRACTORS

Claim Forms:

To expedite the claim process, you may direct the Independent Contractor to complete the claim forms on our website at www.bluestarclaims.com.

Claim Questions:

Once the claim is set up, the handling Adjuster will be the main point of contact. An email will be sent with the Adjuster's contact information once the claim is set up. Claim questions prior to set up can be submitted to serviceteam@bluestarclaims.com.

Loss Run Request:

If you are in need of a loss run, please submit your requests to: bpalmer@bluestarclaims.com

When to contact your insurance broker (not claim related):

Deletes/adds of contractors, changes to policies, and coverage questions.

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INJURED INDEPENDENT CONTRACTOR CLINICS

If an injured independent contractor needs assistance in finding a treating provider, they can search the following clinic websites for locations near them. The below listed clinics specialize with work related injuries.

LIST EMPLOYER AS: **Self Employed BSC**

Concentra®

https://www.concentra.com/urgent-care-centers/

U.S. HealthWorks™

https://www.ushealthworks.com/Medical-Center/Find.html

Medical Centers Nova®

https://n-o-v-a.com/locations/

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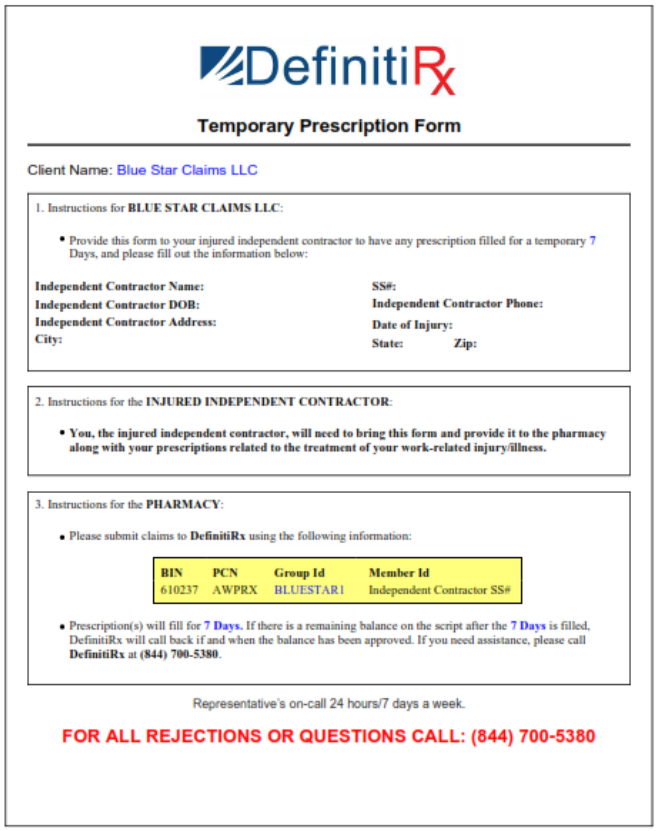
DEFINITI RX PRESCRIPTION CARD PROGRAM
Administered by Blue Star Claims LLC

INDEPENDENT CONTRACTORS

- If you need a prescription filled for an occupational accident injury, please call (844) 700-5380 to get your temporary Member ID #.
- Please take this sheet to any pharmacy and present this sheet to the pharmacy with your Member ID filled out, along with your prescription.
- If your occupational accident claim is accepted, you will receive a more permanent pharmacy card in the mail, via email, or via text message.

PHARMACIST

- The independent contractor will have to call to get their temporary Member ID#.
- All data needed to process this script through the Definiti Rx System is included in the drug card represented below.



DefinitiRx

Temporary Prescription Form

Client Name: Blue Star Claims LLC

1. Instructions for **BLUE STAR CLAIMS LLC**:

- Provide this form to your injured independent contractor to have any prescription filled for a temporary 7 Days, and please fill out the information below:

Independent Contractor Name: **SS#:**
Independent Contractor DOB: **Independent Contractor Phone:**
Independent Contractor Address: **Date of Injury:**
City: **State:** **Zip:**

2. Instructions for the **INJURED INDEPENDENT CONTRACTOR**:

- **You, the injured independent contractor, will need to bring this form and provide it to the pharmacy along with your prescriptions related to the treatment of your work-related injury/illness.**

3. Instructions for the **PHARMACY**:

- Please submit claims to **DefinitiRx** using the following information:

BIN	PCN	Group Id	Member Id
610237	AWPRX	BLUESTAR1	Independent Contractor SS#

- Prescription(s) will fill for **7 Days.** If there is a remaining balance on the script after the **7 Days** is filled, DefinitiRx will call back if and when the balance has been approved. If you need assistance, please call **DefinitiRx** at **(844) 700-5380**.

Representative's on-call 24 hours/7 days a week.

FOR ALL REJECTIONS OR QUESTIONS CALL: (844) 700-5380

Blue Star Claims LLC
21001 N. Tatum Blvd., Suite 1630-646, Phoenix, AZ 85050
Phone: (480) 579-2501 | Fax: (480) 579-2476 | Email: serviceteam@bluestarclaims.com

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ADMINISTERED BY BLUE STAR CLAIMS LLC

Please complete this Occupational Accident claim form by typing or printing clearly in ink and return by mail or fax to:

Blue Star Claims LLC
21001 N. Tatum Blvd., Suite 1630-646
Phoenix, AZ 85050
Fax: (480) 579-2476
Email: serviceteam@bluestarclaims.com

IMPORTANT: IN ORDER TO EXPEDITE THE PROCESSING OF YOUR CLAIM, THIS FORM MUST BE COMPLETED IN ITS ENTIRETY AND RETURNED TO THE ADDRESS INDICATED. FURTHER INFORMATION REGARDING ELIGIBILITY / CONTRACTOR STATUS WILL BE REQUESTED FROM THE COMPANY INDICATED.

Insured's Name: _____ Date of Birth: _____

Address: _____ Home Phone: _____
Street

_____ Cell Phone: _____
City *State* *Zip Code*

Name of the Company you contract with: _____ Phone: _____

Are you an Independent Contractor?: No ☐ Yes ☐ Were you performing your occupational duties at time of injury?: No ☐ Yes ☐

Date of Injury: _____ Date of 1st treatment: _____ Date reported to Company: _____

Type of injury (i.e. sprain, fracture, etc.): _____

Body part(s) & area(s) (i.e. left leg, right arm, etc.): _____

Describe how the accident occurred: _____

Name and complete address of any physician(s) who have treated you for this condition: _____

Have you suffered same or similar condition before?: No ☐ Yes ☐ If Yes, and you were previously treated, dates treated: _____

Name and complete address of **PRIOR** physician(s) who treated you: _____

If hospitalized at that time, list date confined to hospital: _____

Name and address of hospital: _____

Have you been disabled as a result of this accident? No ☐ Yes ☐ First date unable to work: _____

THE ATTACHED ATTENDING PHYSICIAN STATEMENT WILL ALSO NEED TO BE COMPLETED & SIGNED BY YOUR TREATING PHYSICIAN.
AUTHORIZATION: I hereby authorize United States Fire Insurance Company, Blue Star Claims LLC, or its representative, to inspect or secure copies of case history records, laboratory reports, diagnosis, prognosis, x-rays, and any other data covering this and /or previous confinements and/or disabilities. A photostatic copy or facsimile of this authorization shall be deemed as effective and valid as the original. This authorization is valid for twelve (12) months from date of signature. FRAUD WARNING: PLEASE SEE PAGE THREE FOLLOWING FOR ALL STATES OTHER THAN NEW YORK.
FRAUD WARNING: RESIDENTS OF NEW YORK: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR 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, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

BY NOT COMPLETING THIS FORM IN FULL, YOUR CLAIM COULD BE DELAYED

SIGNATURE OF CLAIMANT: _____ **DATE:** _____

CLAIM FORM FRAUD STATEMENT - FOR RESIDENTS OF ALL STATES OTHER THAN THOSE LISTED BELOW:
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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.

ALASKA: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

CALIFORNIA: For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fins and confinement in state prison.

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 policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder 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.

FLORIDA WARNING: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

IDAHO: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

KANSAS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of insurance fraud as determined by a court of law and may be subject to fines and confinement in prison.

KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other 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.

MARYLAND: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NEW HAMPSHIRE: Any person who, with a 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.

NEW JERSEY: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NEW MEXICO and PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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 and subjects such person to criminal and civil penalties.

OHIO: Any person who, with intent to defraud or knowing that he 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.

OKLAHOMA: 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.

TENNESSEE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

TEXAS: Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

VIRGINIA: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

Blue Star Claims LLC

AUTHORIZATION TO DISCLOSE, RELEASE AND USE PROTECTED HEALTH INFORMATION (HIPAA COMPLIANT)

(this section to be filled in by Blue Star Claims LLC)

_____ Date: _____

_____

_____

This authorization permits you to release a copy of **any and all records (even those which predate the injury listed below)** in your possession regarding any pre-employment physicals, DOT physicals, post offer physicals, medical treatment and/or hospitalization of:

Name of Claimant: _____ Date of Birth: _____

Social Security Number: _____

Date(s) of Injury/Occupational Disease: _____

I AUTHORIZE you to disclose any information and records regarding the above named individual in your possession. This includes but is not limited to, your medical findings, diagnosis, treatment, treatment summaries, psychological or psychiatric evaluations, prognosis, clinic notes, diagnostic reports or radiology films, physical therapy records, pharmacy records, or any other health information in your records. I understand that based on the information released it may include information related to any substance abuse.

I UNDERSTAND that the information furnished may be used to evaluate and verify my claim for benefits for a work related injury or occupational disease. The information obtained is relevant to an occupational accident claim(s) and may be used by persons or organizations performing a service related to, or adjudicating the claim(s).

THIS AUTHORIZATION will expire 90 days following a resolution/closure of the occupational injury claim(s) but may be revoked by signator in writing to the requesting party. Revocation of this authorization will not be valid if the requesting party has taken action in reliance upon such authorization. Please note that the information disclosed or used pursuant to this authorization may be subject to re-disclosure and would, therefore, no longer be protected under the terms of the HIPAA privacy rule.

A PHOTOSTATIC COPY of this authorization shall be deemed to have the same authority as the original. **I hereby certify that I have read the provisions in this authorization. I understand and agree to its terms, and authorize disclosure of the information described above.**

_____ _____

Claimant Signature Date

Authorization to obtain non public personal and financial information:

Blue Star Claims will have complete and unrestricted rights to obtain, disclose, release or make use of personal or privileged information about me which may include financial and wage statements, tax records, settlement statements on income, applications for employment or any personnel records to assist in the investigation of my Occupation Injury claim.

_____ _____

Claimant Signature Date

This information is for the sole use of the designated persons and/or entities listed below. Unless required by applicable law or court order, this information will not be given in any identifiable form to any other unauthorized persons or entity unless I agree to release it in writing.

Requesting Party: Blue Star Claims LLC
Address: 21001 North Tatum Blvd., Ste. 1630-646 Phoenix, AZ 85050
Phone Number: (480) 579-2501
Please fax if possible to: (480) 579-2476

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ADMINISTERED BY BLUE STAR CLAIMS LLC

Please complete this form by typing or printing clearly in ink and return by mail or fax to:
**A photostatic copy or facsimile shall be deemed as effective and valid as the original*

Blue Star Claims LLC
21001 N. Tatum Blvd., Suite 1630-646
Phoenix, AZ 85050
Fax: (480) 579-2476
Email: serviceteam@bluestarclaims.com

STATEMENT OF ATTENDING PHYSICIAN

Patient's Name: _____ Date of Birth: _____

1. Complete Diagnosis: _____

2. Is this condition a result of ☐ illness or ☐ injury? If injury, how do you understand the accident occurred?

3. Has the patient had treatment for the same or related condition before? No ☐ Yes ☐ If Yes, when and by whom?

4. Was the patient hospitalized? No ☐ Yes ☐ If Yes, please give name, address of hospital, and date of confinement(s):

Name of facility *Address* *Dates - From / To*

Name of facility *Address* *Dates - From / To*

5. First Date of Treatment: _____ Last Date of Treatment: _____ Next Date of Treatment: _____

6. This disability would be categorized as:

☐ Partial Disability – Patient is able to perform one or more, but not all of the major duties of his/her job.

Dates of Partial Disability From: _____ Through: _____

☐ Total Disability – Patient is unable to perform all of the major duties of his/her job.

Dates of Total Disability From: _____ Through: _____

7. Expected Return to Work Date: _____ Will patient resume full duties upon return to work? No ☐ Yes ☐

If No, please explain: _____

Physician Name and Address: _____

Name *Street* *City* *State* *Zip Code*

Physician Phone Number: _____ Fax Number: _____ TIN or SS#: _____

SIGNATURE OF PHYSICIAN: _____ **DATE:** _____

BLUE STAR
BLUE STAR CLAIMS LLC

Please attach additional pages, if necessary.
This form is required on all Occupational Accident injuries reported. Please return this form as soon as possible with the HIPAA Medical Release to:

Blue Star Claims LLC
21001 N. Tatum Blvd., Suite 1630-646
Phoenix, AZ 85050
Fax: (480) 579-2476
Email: serviceteam@bluestarclaims.com

MEDICAL TREATMENT PROVIDER LIST

Claimant Name: _____ SSN: _____

Street: _____ Date of Injury: _____

City, State ZIP: _____ Name of the Company you contract with: _____

Phone Number: _____ Email Address: _____

This form will expedite the investigation of your Occupational Accident claim under your Independent Contractor policy. We may need to request prior medical records from doctors or facilities you have seen in the past. Please list any medical providers who have treated you for any medical problems within the past 15 years. List medical providers for industrial injury first.

Current Treating Providers
If none, write none

Physician Name: _____
Street: _____
City, State ZIP: _____
Phone Number: _____

Physician Name: _____
Street: _____
City, State ZIP: _____
Phone Number: _____

Physician Name: _____
Street: _____
City, State ZIP: _____
Phone Number: _____

Physician Name: _____
Street: _____
City, State ZIP: _____
Phone Number: _____

Prior Medical Providers
Regardless of condition treated. If none, write none

Physician Name: _____
Street: _____
City, State ZIP: _____
Phone Number: _____
Reason for Tx: _____

Physician Name: _____
Street: _____
City, State ZIP: _____
Phone Number: _____
Reason for Tx: _____

Physician Name: _____
Street: _____
City, State ZIP: _____
Phone Number: _____
Reason for Tx: _____

Physician Name: _____
Street: _____
City, State ZIP: _____
Phone Number: _____
Reason for Tx: _____

CLAIMANT SIGNATURE: _____ **DATE:** _____