Vigilance

Emergency Sharps Information and How to File a Claim

What to do if you are exposed to HIV, Hepatitis B, or Hepatitis C

If you experienced a needlestick or sharps injury or were exposed to the blood or other body fluid of a patient during the course of your work, **immediately follow these steps**:

- ✔ Wash needlesticks and cuts with soap and water
- ✔ Flush splashes to the nose, mouth, or skin with water
- ✔ Irrigate eyes with clean water, saline, or sterile irrigants
- ✔ Report the incident to your supervisor
- ✔ Immediately seek medical treatment

Source: The National Institute for Occupational Safety and Health (NIOSH) https://www.cdc.gov/niosh/topics/bbp/emergnedl.html

How long after exposure can you expect a positive test if infected?

Hepatitis C: HCV infection can be detected by anti-HCV screening tests (enzyme immunoassay) 4–10 weeks after infection. Anti-HCV seroconversion occurs, on average, 8-11 weeks after exposure although cases of delayed seroconversion have been documented with immunosuppression such as in HIV infection. HCV RNA appears in blood and can be detected as early as 2–3 weeks after infection.

Source: Centers for Disease Control and Prevention; https://www.cdc.gov/hepatitis/hcv/hcvfaq.htm

Hepatitis B: Hepatitis B surface antigen (HBsAg) will be detected in an infected person's blood an average of 4 weeks (range: 1–9 weeks) after exposure to the virus. About 1 of 2 patients will no longer be infectious by 7 weeks after onset of symptoms, and all patients who do not remain chronically infected will be HBsAg-negative by 15 weeks after onset of symptoms.

Source: Centers for Disease Control and Prevention; https://www.cdc.gov/hepatitis/hbv/hbvfaq.htm

HIV: No HIV test can detect HIV immediately after infection. If you think you've been exposed to HIV in the last 72 hours, talk to your health care provider about post-exposure prophylaxis (PEP), right away. There are three types of tests available:

- A **nucleic acid test (NAT)** can usually tell you if you have HIV infection 10 to 33 days after an exposure.
- An **antigen/antibody test** performed by a laboratory on blood from a vein can usually detect HIV infection 18 to 45 days after an exposure. Antigen/antibody tests done with blood from a finger prick can take longer to detect HIV (18 to 90 days after an exposure).
- **Antibody tests** can take 23 to 90 days to detect HIV infection after an exposure. Most rapid tests and self-tests are antibody tests. In general, antibody tests that use blood from a vein can detect HIV sooner after infection than tests done with blood from a finger prick or with oral fluid.

Source: Centers for Disease Control and Prevention; https://www.cdc.gov/hiv/basics/testing.html

How to document and submit a claim

- **Step 1:** You must submit an incident report within 48 hours to the employer, healthcare laboratory, or facility for whom duties were performed at the time of the needle stick, sharp injury, or splatter of blood or bodily fluids.
- **Step 2:** You must be tested within 48 hours of the incident for Hepatitis B, Hepatitis C and HIV. The required medical testing must be in accordance with OSHA's stringent medically accepted protocols and the protocol procedures required by the employer, laboratory, or facility for whom duties were performed at the time of the needle stick, sharp injury or splatter of blood or bodily fluids. **PLEASE NOTE: This policy does NOT pay for blood tests or medical expenses associated with the incident.**
- **Step 3:**
  - **For Infected Needlestick Benefit:**
    - Please complete the claim form and mail it to the address below if it can be verified that the patient/source of the exposure was infected with Hepatitis B, Hepatitis C or HIV at the time of the exposure.
    - If this cannot be verified, then you must:
      - first undergo and complete the preferred regime for post-exposure prophylaxis (PEP)/medical protocol procedures required by your employer and in accordance with OSHA's protocols.
      - provide evidence that attempts to have the patient/source's blood tested after the exposure were unsuccessful.

      Please complete and submit your claim once you complete the required PEP protocols and have the necessary evidence ready.
  - **For HIV, Hepatitis B or Hepatitis C Benefits:** You must test NEGATIVE for Hepatitis B, Hepatitis C and HIV as a result of this initial 48-hour test. This test is to determine that prior to exposure you did not have HIV, Hepatitis B or Hepatitis C. If within 180 days of the original incident you test positive for HIV or chronic Hepatitis B or chronic Hepatitis C, please complete the claim form and mail it to the address below with copies of your medical records.

Mail Claim Forms to:

Co-ordinated Benefit Plans on behalf of Berkley Life and Health Insurance Company,
PO Box 21282, Tampa, FL 33623

If you need assistance: Call toll-free 1-866-224-5878 or email BAHclaims@cbpinsure.com

W. R. Berkley Corporation
Notice of Personal Information Collected
(Pursuant to the California Consumer Privacy Act (CCPA))

This notice applies only to information received and collected by W. R. Berkley Corporation ("Berkley") from residents of the state of California.

In this notice, when we refer to "we", "us" or "our", it means one or more operating units of W. R. Berkley Corporation ("Berkley operating units").

When we refer to "you" and "your" in this notice, we mean a resident of the state of California whose personal information we may collect. More information about W. R. Berkley Corporation operating unit subsidiaries can be found on https://www.berkley.com/our-business/operating-units.

Below is a table showing the categories of personal information that one or more of the Berkley operating units collect in the course of performing insurance services and how it is used, Not every Berkley operating unit collects every category of personal information or uses it in all the ways listed below.

Personal Information Category	How it is Used
Identifiers (such as name, address, social security #, driver's license #, etc.) **Other Sensitive Information under California Law** *(Examples: physical description, financial information, medical information, etc.)* **Characteristics of protected classifications under California or federal law** *(Examples: race, sex, color, religion, national origin, marital status, etc.)* **Biometric information** *(Examples: fingerprints, keystroke patterns, gait patterns, sleep/health data, etc.)* **Geolocation Data** *(Information to identify physical location)* **Audio, electronic, visual, thermal, olfactory, or similar information.** *(Examples: audio and video recordings)* **Professional or employment-related information.** *(Example: job history)* **Education information** (information not publicly available as defined under federal law)	To perform insurance services for policyholders/ beneficiaries/claimants; maintain and improve quality of services; security; prevent fraud and improper use; internal research; identify and repair errors; comply with laws and regulations.

Commercial information *(Examples: records of personal property, products, and services purchased or obtained, etc.)*	To perform insurance services for policyholders/ beneficiaries/claimants; security; prevent fraud and improper use; internal research; collections; comply with laws and regulations.
Internet or other electronic network activity information *(Examples: browsing/search history, visitor's interaction with a website, etc.)*	To perform insurance services for policyholders/ beneficiaries/claimants; maintain and improve quality of services; security; prevent fraud and improper use; internal research; identify and repair errors; comply with laws and regulations.
Inferences drawn from any of the other categories of information. (use of any of the above categories to create a profile about a consumer)	To perform insurance services for policyholders/ beneficiaries/claimants; maintain and improve quality of services; security; prevent fraud and improper use; internal research; identify and repair errors; comply with laws and regulations.

NEED MORE INFORMATION?

For additional information about how we collect, use, and share personal information, about California consumers' rights under the CCPA, and to make a consumer request, please see our online Privacy Policy at: https://www.berkley.com/privacy

This notice was updated on December 30, 2019

INDIVIDUAL OCCUPATIONAL ACCIDENT -
FELONIOUS ASSAULT HOSPITAL CONFINEMENT BENEFIT
Claim Form & Claimant's Statement

Insurance coverage is underwritten by Berkley Life and Health Insurance Company, (domiciled in Iowa - California Certificate of Authority #08527), 2445 Kuser Road, Suite 201, Hamilton Square, NJ 08690.
Policy Form Series: BI-10000P and Rider Form Series: BI-10005R

Instructions for Submitting a Claim:

1. This claim form must be completed in its entirety and properly signed by the named insured or authorized representative. The claim form must be submitted within 90 days after the date of loss.

2. In the event that a claim is not submitted in full, or if additional information is needed, the claim will be marked incomplete and the additional information will be requested via US Mail. Please forward the requested information immediately so that we may finish adjudicating your claim in a swift manner. The explanation of benefits form advising what is needed will be sent to the address of the policyholder listed on the claim form.

Claim Documentation

The minimum documentation required is that specifically identified by the master policy in conjunction with any of the applicable riders. That documentation includes but is not necessarily limited to copies of the following:

1. The incident report filed with the employer, medical facility, etc. within the time frame specified by the policy/rider

2. The police report filed within 24 hours after the felonious assault (as it relates to the Felonious Assault Benefit)

3. Documentation that the claimant was admitted to a hospital as an inpatient within the felonious assault incurral period stated in the policy/rider

4. This claim form properly completed and signed by the named insured or authorized representative.

** Please be sure to keep copies of all documentation submitted concerning this claim.

Mail Claim Forms To:

Co-ordinated Benefit Plans on behalf of Berkley Life and Health Insurance Company
PO Box 21282
Tampa, FL 33623

If You Need Immediate Assistance, Please Call or Write to Us at:

TOLL FREE 1-866-224-5878 / EMAIL: BAHclaims@cbpinsure.com

POLICYHOLDER INFORMATION:

Policyholder First and Last Name: _____

Date of Birth: _____ Policy #: _____

Email Address: _____ Home Phone #: (_____)_____

Work Phone: (_____) _____/_____ Cell #: (_____) _____

Policyholder Home Address:_____

City: _____ State:_____ Zip Code:_____

EMPLOYER/SCHOOL INFORMATION:

Legal Name:_____
(or the healthcare, laboratory, or public-safety setting/facility for whom or in which You were performing the Occupational Duties at the time of the Incident)

OCCUPATIONAL DUTIES PERFORMED:

_____

_____

LOSS INFORMATION:

Date of Accident: _____ /_____ /_____ Time of Accident _____ ☐ AM ☐ PM

Date of Incident Report: _____ /_____ /_____

Where did the accident occur? _____

How did the accident occur? _____

_____

_____

Who was involved? _____

Are there any further details that you would like to provide concerning your claim? _____

_____

_____

_____

_____

Did you submit an incident report? ☐ Yes ☐ No

(*A copy of the incident report must be submitted with this claim form)

Hospital Confinement Dates: From _____ To _____

Hospital Name: _____

Hospital Address: _____

City:_____ State:_____ Zip Code:_____

Phone #: _____

Did anyone witness the accident? ☐ Yes ☐ No

If yes, please provide the full names and contact information: _____

_____

Employer/School contact information:

Contact:_____ Phone #: (_____)_____

Address:_____ City:_____ State:____ Zip Code:_____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION:

I hereby authorize any licensed physician; medical practitioner; hospital; clinic or other medical facility; insurance company; employer; Medical Information Bureau; Motor Vehicle Administration or other organization; or persons that have any records or knowledge of me or my physical or mental health condition to give Co-Ordinated Benefit Plans (CBP), its authorized representative, and any agent acting on their behalf any such information. I understand that this information will be used to determine my eligibility for coverage and that I may revoke this authorization at any time by providing written notice. A photocopy of this authorization shall be as valid as the original. This authorization shall be valid for 24 months from the date below (In CA, CT, GA, HIL, MA, MN, NC, NJ, OH, and VA authorization shall be valid during the duration of the claim). I acknowledge that I, or my authorized representative, is entitled to receive a copy of this authorization.

Important Notice: 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. **For 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. (Fraud language varies by state, for additional state specific fraud warning language, please see below)

_____
Name of Insured or Authorized Representative

_____ _____
Signature of Insured or Authorized Representative Date

FRAUD WARNING NOTICES:

For residents of 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.

For residents of 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.

For residents of 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 fines and confinement in state prison.

For residents of 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.

For residents of Delaware and Idaho: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information is guilty of a felony.

For residents of Florida: 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.

For residents of 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.

For residents of 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.

For residents of 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.

For residents of 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.

For residents of Maine, Tennessee, Virginia and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

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

For residents of 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.

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

For residents of New Mexico: 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 CIVIL FINES AND CRIMINAL PENALTIES.

For residents of Ohio and Oklahoma: 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.

For residents of Oregon: 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 a crime and may be subject to fines and confinement in prison.

For residents of 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.

For residents of Vermont: Any person who knowingly presents a false statement in a claim for proceeds of an insurance policy may be guilty of a criminal offense and subject to penalties under state law.

W. R. Berkley Corporation

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When we refer to "you" and "your" in this notice, we mean a resident of the state of California whose personal information we may collect. More information about W. R. Berkley Corporation operating unit subsidiaries can be found on https://www.berkley.com/our-business/operating-units.
Below is a table showing the categories of personal information that one or more of the Berkley operating units collect in the course of performing insurance services and how it is used, Not every Berkley operating unit collects every category of personal information or uses it in all the ways listed below.

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Identifiers (such as name, address, social security #, driver's license #, etc.) **Other Sensitive Information under California Law** *(Examples: physical description, financial information, medical information, etc.)* **Characteristics of protected classifications under California or federal law** *(Examples: race, sex, color, religion, national origin, marital status, etc.)* **Biometric information** *(Examples: fingerprints, keystroke patterns, gait patterns, sleep/health data, etc.)* **Geolocation Data** *(Information to identify physical location)* **Audio, electronic, visual, thermal, olfactory, or similar information.** *(Examples: audio and video recordings)* **Professional or employment-related information.** *(Example: job history)* **Education information** (information not publicly available as defined under federal law)	To perform insurance services for policyholders/ beneficiaries/claimants; maintain and improve quality of services; security; prevent fraud and improper use; internal research; identify and repair errors; comply with laws and regulations.

Commercial information *(Examples: records of personal property, products, and services purchased or obtained, etc.)*	To perform insurance services for policyholders/ beneficiaries/claimants; security; prevent fraud and improper use; internal research; collections; comply with laws and regulations.
Internet or other electronic network activity information *(Examples: browsing/search history, visitor's interaction with a website, etc.)*	To perform insurance services for policyholders/ beneficiaries/claimants; maintain and improve quality of services; security; prevent fraud and improper use; internal research; identify and repair errors; comply with laws and regulations.
Inferences drawn from any of the other categories of information. (use of any of the above categories to create a profile about a consumer)	To perform insurance services for policyholders/ beneficiaries/claimants; maintain and improve quality of services; security; prevent fraud and improper use; internal research; identify and repair errors; comply with laws and regulations.

NEED MORE INFORMATION?
For additional information about how we collect, use, and share personal information, about California consumers' rights under the CCPA, and to make a consumer request, please see our online Privacy Policy at: https://www.berkley.com/privacy

This notice was updated on December 30, 2019

INDIVIDUAL OCCUPATIONAL ACCIDENT – HIV, CHRONIC HEPATITIS B OR C
Claim Form & Claimant's Statement

Insurance coverage is underwritten by Berkley Life and Health Insurance Company, (domiciled in Iowa - California Certificate of Authority #08527), 2445 Kuser Road, Suite 201, Hamilton Square, NJ 08690.
Policy Form Series: BI-10000P and Rider Form Series: BI-10008R

Instructions for Submitting a Claim:

1. This claim form must be completed in its entirety and properly signed by the named insured or authorized representative. The claim form must be submitted within 90 days after the date of loss.

2. In the event that a claim is not submitted in full, or if additional information is needed, the claim will be marked incomplete and the additional information will be requested via US Mail. Please forward the requested information immediately so that we may finish adjudicating your claim in a swift manner. The explanation of benefits form advising what is needed will be sent to the address of the policyholder listed on the claim form.

Claim Documentation

The minimum documentation required is that specifically identified by the master policy in conjunction with any of the applicable riders. That documentation includes but is not necessarily limited to copies of the following:

1. The incident report filed with the employer, medical facility, etc. within 48 hours of the incident

2. Documentation that the initial medical testing of the claimant after exposure required by the policy/rider

   1) was done within 48 hours of the incident; and
   2) produced a negative result

3. Documentation that any subsequent medical testing of the claimant required by the policy/rider

   1) was done within 180 days of the incident; and
   2) produced a positive result

4. Documentation that any medical treatment of the claimant required by the policy/rider was in fact rendered

5. This claim form properly completed and signed by the named insured or authorized representative.

** Please be sure to keep copies of all documentation submitted concerning this claim.

Mail Claim Forms To:

Co-ordinated Benefit Plans on behalf of Berkley Life and Health Insurance Company
PO Box 21282
Tampa, FL 33623

If You Need Immediate Assistance, Please Call or Write to Us at:

TOLL FREE 1-866-224-5878 / EMAIL: BAHclaims@cbpinsure.com

POLICYHOLDER INFORMATION:

Policyholder First and Last Name: _____

Date of Birth: _____ Policy #: _____

Email Address: _____ Home Phone #: (_____)_____

Work Phone: (_____) _____/_____ Cell #: (_____) _____

Policyholder Home Address:_____

City: _____ State:_____ Zip Code:_____

EMPLOYER/SCHOOL INFORMATION:

Legal Name:_____
(or the healthcare, laboratory, or public-safety setting/facility for whom or in which You were performing the Occupational Duties at the time of the Incident)

OCCUPATIONAL DUTIES PERFORMED:

_____

_____

LOSS INFORMATION:

Date of Accident: _____ /_____ /_____ Time of Accident _____ ☐ AM ☐ PM

Date of Incident Report: _____ /_____ /_____

Where did the accident occur? _____

How did the accident occur? _____

_____

_____

What are you claiming to have contracted from the accident? ☐ HIV ☐ Hepatitis B ☐ Hepatitis C

Did anyone witness the accident? ☐ Yes ☐ No

If yes, please provide the full names and contact information: _____

_____

Are there any further details that you would like to provide concerning your claim? _____

_____

_____

Did you submit an incident report within 48 hours of the incident? ☐ Yes ☐ No
(*A copy of the incident report must be submitted with this claim form)

Did you get tested within 48 hours of the incident for the disease which you are claiming to have contracted?

☐ Yes ☐ No

If Yes, was the result of that test negative? ☐ Yes ☐ No

Were you subsequently tested within 180 days of the incident for the disease which you are claiming to have contracted?

☐ Yes ☐ No

If Yes, was the result of that test positive? ☐ Yes ☐ No

Employer/School contact information:

Contact:_____ Phone #: (_____)_____

Address:_____ City:_____ State:____ Zip Code:_____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION:

I hereby authorize any licensed physician; medical practitioner; hospital; clinic or other medical facility; insurance company; employer; Medical Information Bureau; Motor Vehicle Administration or other organization; or persons that have any records or knowledge of me or my physical or mental health condition to give Co-Ordinated Benefit Plans (CBP), its authorized representative, and any agent acting on their behalf any such information. I understand that this information will be used to determine my eligibility for coverage and that I may revoke this authorization at any time by providing written notice. A photocopy of this authorization shall be as valid as the original. This authorization shall be valid for 24 months from the date below (In CA, CT, GA, HIL, MA, MN, NC, NJ, OH, and VA authorization shall be valid during the duration of the claim). I acknowledge that I, or my authorized representative, is entitled to receive a copy of this authorization.

Important Notice: 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. **For 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. (Fraud language varies by state, for additional state specific fraud warning language, please see below)

_____
Name of Insured or Authorized Representative

_____ _____
Signature of Insured or Authorized Representative Date

FRAUD WARNING NOTICES:

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For residents of 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.

For residents of 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 fines and confinement in state prison.

For residents of 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.

For residents of Delaware and Idaho: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information is guilty of a felony.

For residents of Florida: 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.

For residents of 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.

For residents of 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.

For residents of 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.

For residents of 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.

For residents of Maine, Tennessee, Virginia and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

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

For residents of 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.

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

For residents of New Mexico: 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 CIVIL FINES AND CRIMINAL PENALTIES.

For residents of Ohio and Oklahoma: 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.

For residents of Oregon: 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 a crime and may be subject to fines and confinement in prison.

For residents of 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.

For residents of Vermont: Any person who knowingly presents a false statement in a claim for proceeds of an insurance policy may be guilty of a criminal offense and subject to penalties under state law.

W. R. Berkley Corporation

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Personal Information Category	How it is Used
Identifiers (such as name, address, social security #, driver's license #, etc.) **Other Sensitive Information under California Law** *(Examples: physical description, financial information, medical information, etc.)* **Characteristics of protected classifications under California or federal law** *(Examples: race, sex, color, religion, national origin, marital status, etc.)* **Biometric information** *(Examples: fingerprints, keystroke patterns, gait patterns, sleep/health data, etc.)* **Geolocation Data** *(Information to identify physical location)* **Audio, electronic, visual, thermal, olfactory, or similar information.** *(Examples: audio and video recordings)* **Professional or employment-related information.** *(Example: job history)* **Education information** (information not publicly available as defined under federal law)	To perform insurance services for policyholders/ beneficiaries/claimants; maintain and improve quality of services; security; prevent fraud and improper use; internal research; identify and repair errors; comply with laws and regulations.
Commercial information *(Examples: records of personal property, products, and services purchased or obtained, etc.)*	To perform insurance services for policyholders/ beneficiaries/claimants; security; prevent fraud and improper use; internal research; collections; comply with laws and regulations.

Internet or other electronic network activity information *(Examples: browsing/search history, visitor's interaction with a website, etc.)*	To perform insurance services for policyholders/ beneficiaries/claimants; maintain and improve quality of services; security; prevent fraud and improper use; internal research; identify and repair errors; comply with laws and regulations.
Inferences drawn from any of the other categories of information. (use of any of the above categories to create a profile about a consumer)	To perform insurance services for policyholders/ beneficiaries/claimants; maintain and improve quality of services; security; prevent fraud and improper use; internal research; identify and repair errors; comply with laws and regulations.

NEED MORE INFORMATION?
For additional information about how we collect, use, and share personal information, about California consumers' rights under the CCPA, and to make a consumer request, please see our online Privacy Policy at: https://www.berkley.com/privacy

This notice was updated on December 30, 2019

INDIVIDUAL OCCUPATIONAL ACCIDENT – INFECTED NEEDLESTICK
Claim Form & Claimant's Statement

Insurance coverage is underwritten by Berkley Life and Health Insurance Company, (domiciled in Iowa - California Certificate of Authority #08527), 2445 Kuser Road, Suite 201, Hamilton Square, NJ 08690.
Policy Form Series: BI-10000P and Rider Form Series: BI-10006R

Instructions for Submitting a Claim:

1. This claim form must be completed in its entirety and properly signed by the named insured or authorized representative. The claim form must be submitted within 90 days after the date of loss.

2. In the event that a claim is not submitted in full, or if additional information is needed, the claim will be marked incomplete and the additional information will be requested via US Mail. Please forward the requested information immediately so that we may finish adjudicating your claim in a swift manner. The explanation of benefits form advising what is needed will be sent to the address of the policyholder listed on the claim form.

Claim Documentation

The minimum documentation required is that specifically identified by the master policy in conjunction with any of the applicable riders. That documentation includes but is not necessarily limited to copies of the following:

1. The incident report filed with the employer, medical facility, etc. within 48 hours of the incident.

2. Documentation that the source/patient of potential exposure for the claimant was infected with either Hepatitis B, Hepatitis C or HIV (If it can be verified)

3. Documentation that the medical testing of the claimant after exposure required by the policy/rider was done within 48 hours of the incident.

4. Documentation that shows attempts were made to have the source/patient's blood tested, after the needlestick exposure, were unsuccessful

5. Documentation that any medical treatment of the claimant required by the policy/rider was in fact rendered within 48 hours of the incident

6. Documentation that the claimant underwent and completed the preferred regime for post-exposure prophylaxis (PEP)/medical protocol

7. This claim form properly completed and signed by the named insured or authorized representative.

** Please be sure to keep copies of all documentation submitted concerning this claim.

Mail Claim Forms To:

Co-ordinated Benefit Plans on behalf of Berkley Life and Health Insurance Company
PO Box 21282
Tampa, FL 33623

If You Need Immediate Assistance, Please Call or Write to Us at:

TOLL FREE 1-866-224-5878 / EMAIL: BAHclaims@cbpinsure.com

POLICYHOLDER INFORMATION:

Policyholder First and Last Name: _____

Date of Birth: _____ Policy #: _____

Email Address: _____ Home Phone #: (_____)_____

Work Phone: (_____) _____/_____ Cell #: (_____) _____

Policyholder Home Address:_____

City: _____ State:_____ Zip Code:_____

EMPLOYER/SCHOOL INFORMATION:

Legal Name:_____
(or the healthcare, laboratory, or public-safety setting/facility for whom or in which You were performing the Occupational Duties at the time of the Incident)

OCCUPATIONAL DUTIES PERFORMED:

_____

_____

LOSS INFORMATION:

Date of Accident: _____ /_____ /_____ Time of Accident _____ ☐ AM ☐ PM

Date of Incident Report: _____ /_____ /_____

Where did the accident occur? _____

How did the accident occur? _____

_____

_____

What are you claiming to have had exposure to the accident? ☐ HIV ☐ Hepatitis B ☐ Hepatitis C

Did anyone witness the accident? ☐ Yes ☐ No

If yes, please provide the full names and contact information: _____

_____

Are there any further details that you would like to provide concerning your claim? _____

_____

_____

_____

_____

Did you submit an incident report for the Needlestick exposure? ☐ Yes ☐ No

(*A copy of the incident report must be submitted with this claim form)

Employer/School contact information:

Contact:_____ Phone #: (_____)_____

Address:_____ City:_____ State:____ Zip Code:_____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION:

I hereby authorize any licensed physician; medical practitioner; hospital; clinic or other medical facility; insurance company; employer; Medical Information Bureau; Motor Vehicle Administration or other organization; or persons that have any records or knowledge of me or my physical or mental health condition to give Co-Ordinated Benefit Plans (CBP), its authorized representative, and any agent acting on their behalf any such information. I understand that this information will be used to determine my eligibility for coverage and that I may revoke this authorization at any time by providing written notice. A photocopy of this authorization shall be as valid as the original. This authorization shall be valid for 24 months from the date below (In CA, CT, GA, HIL, MA, MN, NC, NJ, OH, and VA authorization shall be valid during the duration of the claim). I acknowledge that I, or my authorized representative, is entitled to receive a copy of this authorization.

Important Notice: 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. **For 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. (Fraud language varies by state, for additional state specific fraud warning language, please see below)

_____
Name of Insured or Authorized Representative

_____ _____
Signature of Insured or Authorized Representative Date

FRAUD WARNING NOTICES:

For residents of 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.

For residents of 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.

For residents of 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 fines and confinement in state prison.

For residents of 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.

For residents of Delaware and Idaho: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information is guilty of a felony.

For residents of Florida: 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.

For residents of 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.

For residents of 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.

For residents of 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.

For residents of 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.

For residents of Maine, Tennessee, Virginia and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

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

For residents of 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.

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

For residents of New Mexico: 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 CIVIL FINES AND CRIMINAL PENALTIES.

For residents of Ohio and Oklahoma: 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.

For residents of Oregon: 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 a crime and may be subject to fines and confinement in prison.

For residents of 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.

For residents of Vermont: Any person who knowingly presents a false statement in a claim for proceeds of an insurance policy may be guilty of a criminal offense and subject to penalties under state law.

W. R. Berkley Corporation

Notice of Personal Information Collected

(Pursuant to the California Consumer Privacy Act (CCPA))

This notice applies only to information received and collected by W. R. Berkley Corporation ("Berkley") from residents of the state of California.

In this notice, when we refer to "we", "us" or "our", it means one or more operating units of W. R. Berkley Corporation ("Berkley operating units").

When we refer to "you" and "your" in this notice, we mean a resident of the state of California whose personal information we may collect. More information about W. R. Berkley Corporation operating unit subsidiaries can be found on https://www.berkley.com/our-business/operating-units.
Below is a table showing the categories of personal information that one or more of the Berkley operating units collect in the course of performing insurance services and how it is used, Not every Berkley operating unit collects every category of personal information or uses it in all the ways listed below.

Personal Information Category	How it is Used
Identifiers (such as name, address, social security #, driver's license #, etc.) **Other Sensitive Information under California Law** *(Examples: physical description, financial information, medical information, etc.)* **Characteristics of protected classifications under California or federal law** *(Examples: race, sex, color, religion, national origin, marital status, etc.)* **Biometric information** *(Examples: fingerprints, keystroke patterns, gait patterns, sleep/health data, etc.)* **Geolocation Data** *(Information to identify physical location)* **Audio, electronic, visual, thermal, olfactory, or similar information.** *(Examples: audio and video recordings)* **Professional or employment-related information.** *(Example: job history)* **Education information** (information not publicly available as defined under federal law)	To perform insurance services for policyholders/ beneficiaries/claimants; maintain and improve quality of services; security; prevent fraud and improper use; internal research; identify and repair errors; comply with laws and regulations.
Commercial information *(Examples: records of personal property, products, and services purchased or obtained, etc.)*	To perform insurance services for policyholders/ beneficiaries/claimants; security; prevent fraud and improper use; internal research; collections; comply with laws and regulations.

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