CLAIM TRANSMITTAL FORM

TO:	Qual-Lynx 100 Decadon Drive Egg Harbor Twp., NJ 08234
PHONE:	609-653-8400
FAX NUMBER: *(Only for Workers' Compensation)*	**609-601-3196**
FAX NUMBER: *(All other claim reports and information transmitted)*	**609-926-9270**
NUMBER OF PAGES SENT *(#)*	

FROM: *(Name of Claim Coordinator)*	
(Name of District)	

PHONE: *(Telephone number)*	
FAX: *(FAX number)*	
DATE:	
FORM OF TRANSMISSION *(check which applies)*	☐ Fax ☐ Telephone

This is a: ☐ New Claim
☐ Additional Information on Existing Claim

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(*Claim Number, if known*)

Date of Loss: ____________________________________

(*Date of Incident*)

Claimant Name:____________________________________

(*Name of claimant or district*)

Claim Type: ☐ Property/Theft/Employee Dishonesty

☐ Liability or Automobile Physical Damage

☐ Workers' Compensation (employee injured on the job)

Department: **(please check the appropriate box)**

☐ Administration
☐ Facilities/Maintenance/Custodial
☐ Food Service
☐ Instructional Staff
☐ Transportation

Always complete this form whenever transmitting claim information to Qual-Lynx

Check **All** Claim Forms Which Are Attached

☐ Incident Reporting Form

☐ Worker's Compensation Claim Forms

☐ Property Loss\Claim Form

☐ Liability Loss Claim Form

☐ Other relevant information, please explain:

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☐ Tort Notice Information - See Below.

Tort Notice Section (*Third Party Liability Claims*)

- ☐ Initial letter and form sent to claimant (third party) with copies to the Fund's Claim Administrator and Attorney.
- ☐ Completed form received, date stamped, copied and sent to the Fund's Claim Administrator and Attorney.