

ACCIDENT/SICKNESS CLAIM REPORT

Please Complete and Mail To:

PLEASE COMPLETE THIS FORM
IN FULL FOR PROMPT SERVICE.



VFIS
P.O. Box 5126, York, Pennsylvania 17405-9726
Call (717) 741-0911 · Toll Free: (800) 233-1957
Fax (717) 747-7051

NOTE: IMPORTANT STATE INFORMATION
ON REVERSE SIDE

DATE OF THIS REPORT \_\_\_\_\_

TO BE COMPLETED BY INJURED PERSON

Name \_\_\_\_\_ Home Telephone No. (AC ) \_\_\_\_\_
Work Telephone No. (AC ) \_\_\_\_\_
Soc. Sec. No. \_\_\_\_\_
Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
Date of Accident or Organization's Activity \_\_\_\_\_ Year: \_\_\_\_\_ Occurred \_\_\_\_\_ am
Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_ Marital Status \_\_\_\_\_ pm
Full-Time/Regular Occupation \_\_\_\_\_ Income: Weekly \_\_\_\_\_ Yearly \_\_\_\_\_
Name and address of full-time employer \_\_\_\_\_
Employer Telephone No.: \_\_\_\_\_ Length of employment in this work: \_\_\_\_\_

Please completely answer the next three questions:

1. What activity were you involved in when injured or became ill?

\_\_\_\_\_

2. How did accident or sickness occur?

\_\_\_\_\_

3. What is your injury or sickness?

\_\_\_\_\_

Give date of first day of full-time occupation missed due to above accident and sickness \_\_\_\_\_

Give date you were able to return to work \_\_\_\_\_

Attending Physician's Name, Address and Telephone Number \_\_\_\_\_

Name and Address of Hospital \_\_\_\_\_ Dates Hospitalized
From \_\_\_\_\_ Year
To \_\_\_\_\_ Year

AUTHORIZATION TO DOCTOR, HOSPITAL, CLINIC, OR WORKERS' COMPENSATION CARRIER TO RELEASE MEDICAL INFORMATION

Please furnish VFIS, Inc. with information they may request regarding details of my past medical history and physical condition. A photostatic copy of this authorization shall be considered as valid as the original. Your help is greatly appreciated.

Signature of Injured Member or Next of Kin \_\_\_\_\_ Relationship \_\_\_\_\_ Date \_\_\_\_\_

TO BE COMPLETED BY OFFICIAL OF NAMED INSURED ORGANIZATION (must be other than Injured Person)

- Was the injured person a member of your organization at the time of the above described incident? Yes No
• If claimant is a member of organization, please circle type of member: junior adult auxiliary (Circle one)
• Was the injured person engaged in an authorized activity of your organization at the time of injury or commencement of sickness? Yes No
• Name and Address of Insured Organization
• Policy Number \_\_\_\_\_
• Organization Telephone Number \_\_\_\_\_
• Home Telephone Number of Official Signing Below \_\_\_\_\_

I certify that the above is true.

• Signed \_\_\_\_\_ • Title \_\_\_\_\_ • Date \_\_\_\_\_

# ATTENDING PHYSICIAN'S STATEMENT

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Name of Patient \_\_\_\_\_ Age \_\_\_\_\_  
Address \_\_\_\_\_ Telephone \_\_\_\_\_  
Regular Occupation \_\_\_\_\_  
Name of Insured Organization \_\_\_\_\_ Policy No. \_\_\_\_\_

**IMPORTANT**

**Have Insured Member (Patient) sign following Authorization**

I hereby authorize any hospital, physician, or other person who has attended me or examined me to furnish to VFIS, Inc., any and all information with respect to any accident or illness, medical history, consultation, prescriptions or treatment, and copies of all hospital or medical records. A photostatic copy of this authorization shall be considered as effective and valid as the original.

Signature \_\_\_\_\_  
Insured Member Patient

**PART B – TO BE COMPLETED BY ATTENDING PHYSICIAN**

Dear Doctor:

The above named individual has filed a claim for benefits as a result of the Accident/Sickness for which he is currently or has been under your care. In order that we might give his claim proper attention, would you kindly answer the following questions at your earliest convenience and forward completed form to us. ***\*The Company does not assume any expense incidental to the completion of this form.***

- 
- (1) Diagnosis and Concurrent Conditions  
(If Fracture or Dislocation, Describe Nature and Location,  
If Sickness Describe Nature)
- 
- (2A) When Did Symptoms First Appear or Accident Happen? Date \_\_\_\_\_ Year \_\_\_\_\_
- (B) When Did Patient Consult You For This Condition? Date \_\_\_\_\_ Year \_\_\_\_\_
- (C) Has Patient Ever Had Same or Similar Condition?  
(If Yes, State When and Describe) Yes \_\_\_\_\_ No \_\_\_\_\_ Year \_\_\_\_\_
- 
- (3A) Nature of Surgical Procedure, If Any (Describe Fully)- Date Performed \_\_\_\_\_ Year \_\_\_\_\_
- (B) If Performed in Hospital, Give Name and Address - Inpatient \_\_\_\_\_ Outpatient \_\_\_\_\_
- 
- (4) What other Services, If Any, Did You Provide Patient?
- 
- (5) Is Patient Still Under Your Care For This Condition? Yes \_\_\_\_\_ No \_\_\_\_\_  
If "No" Give Date Your Services Terminated. Date \_\_\_\_\_
- 
- (6A) How Long Was or Will Patient Be Continuously  
Totally Disabled (**Unable To perform Regular Occupation**)  
Due to Diagnosis in #1 Above? From \_\_\_\_\_ Year Thru \_\_\_\_\_ Year \_\_\_\_\_
- (B) How Long Was or Will Patient Be Partially Disabled? From \_\_\_\_\_ Year Thru \_\_\_\_\_ Year \_\_\_\_\_
- (C) Approximate Date Patient Will Return To Work If  
Still Disabled. \_\_\_\_\_ Year \_\_\_\_\_

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Date \_\_\_\_\_ Signature \_\_\_\_\_  
(attending physician) (degree) (telephone no.)  
Street Address City or Town State or Providence Zip Code

**Applicable in Pennsylvania**

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 hereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**Applicable in 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.

**Applicable in California**

For your protection, California law requires the following to appear in 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.

**Applicable in all other states**

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.