

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

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 _____