

# 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 17405-9792  
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

Home Telephone No. (AC ) \_\_\_\_\_  
 Work Telephone No. (AC ) \_\_\_\_\_  
 Cell Phone No. (AC ) \_\_\_\_\_  
 Soc. Sec. No. \_\_\_\_\_

Name \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Email Address \_\_\_\_\_ am  
 Date of Accident or Organization's Activity \_\_\_\_\_ Year: \_\_\_\_\_ Occurred \_\_\_\_\_ pm  
 Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_ Marital Status \_\_\_\_\_  
 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 activity described in #1 above an authorized activity of your organization? 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 \_\_\_\_\_

**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.