ACCIDENT & SICKNESS CLAIM REPORT

Reset Form | Print Form

Please Complete and Mail to:

VFIS Claims Management
P.O. Box 5126, York, PA 17405-9792
(800) 233-1957, Fax:(717)747-7051
claims@glatfelters.com

PLEASE COMPLETE THIS FORM and THE ATTACHED MEDICAL AUTHORIZATION IN FULL FOR PROMPT SERVICE

NOTE: Important State Information Included

SECTION 1 - CLAIMANT INFORMATION

*Date of Report*_____

To be completed by the injured person, or next of kin if the claimant is unable or a fatality has occurred.

Home Phone (____)_____ Cell Phone (____)_____ Work Phone (____)_____

Name_____ Soc. Sec. No._____ Date of Birth _____

Home Address_____ City_____ State_____ Zip_____

Email Address_____ Weight_____ Height _____

Gender_____ Marital Status_____ Name of Spouse (if applicable) _____

Full-Time/Regular Occupation_____ Annual Income $_____ Hrly Rate $_____

Name/Address of Full-time Employer _____

Length of Employment in this Work_____ Employer's Phone Number _____

Date of Incident or Organization's Activity_____ Year _____ Time_____ ☐ AM ☐ PM

SECTION 2 - INCIDENT AND MEDICAL TREATMENT INFORMATION

1. What was the activity you were involved in and how did the injury or illness occur?

2. Please provide the diagnosis of your injury or illness.

3. Date of first day of **full-time occupation** missed due to above injury or illness (if applicable)_____ N/A ☐
4. Date able to return to work (if applicable)_____ N/A ☐
5. Attending Physician's Name, Address and Telephone Number _____
6. Name and Address of Hospital _____
   Date Hospitalized From_____ To _____

SECTION 3 -AUTHORIZATION TO EMPLOYER, INSURANCE COMPANY OR WORKERS' COMPENSATION CARRIER TO RELEASE EMPLOYMENT or DISABILITY RELATED INFORMATION

I authorize any Employer, Insurance Company, Workers' Compensation Carrier, Person or Organization to release information regarding my medical treatment, earnings, or benefits payable, including disability or employment related information, to VFIS Claims Management for the purpose of determining benefits that may be payable under the VFIS Accident and Sickness (A&S) policy. A photocopy or digital copy of this authorization is valid in place of the form containing my original signature. This authorization shall be valid for the duration of my claim.

_____ _____ _____

Signature of Injured Member or Next of Kin | Relationship

SECTION 4 – CERTIFICATION

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 incident described in Section 1? ☐ Yes ☐ No
- If you responded yes to the previous question, please select type of member: ☐ Career ☐ Volunteer ☐ Junior ☐ Auxiliary
- Was the injured person participating in an authorized activity of the named insured organization at the time of injury? ☐ Yes ☐ No
- **Name and Address of Organization**

_____

_____

_____

- Policy Number _____
- Organization Telephone Number _____

Contact Number of Official Signing Below_____

I certify that the above information is true.

Signed_____ Title_____ Date_____

Print Name: _____ Email address: _____

March 2023 update

Fraud Warning

It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Applicable in 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.

Applicable in California

For your protection California law requires the following to appear on this form: Any person who knowingly presents 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 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.

Applicable in 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.

Applicable in New Jersey

Any person who knowingly files a statement of claim containing any false or misleading information is subject 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 Pennsylvania

WARNING: Any person who knowingly and with intent to injure or defraud any insurer files an application or claim containing any false, incomplete or misleading information shall, upon conviction, be subject to imprisonment for up to seven years and the payment of a fine of up to $15,000.

Applicable in Rhode Island

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.

Applicable in West Virginia

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.

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.

VFIS Claims Management
183 Leader Heights Road | P.O. Box 5126 | York, PA 17405
717.741.0911 | 800.233.1957 | f: 717.747.7051 | CA License #2D89880

Claimant:
Date of Injury:
Social Security
Date of Birth:

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

This authorization complies with 45 C.F.R. § 164.508

I authorize and direct any health care provider, or workers' compensation carrier to disclose to VFIS Claims Management, their employees, agents, and representatives all health information, including, but not limited to, complete medical history, examination notes and reports, treatment and referral recommendations and records, and diagnosis and prognosis records.

The purpose for this disclosure authorization is the investigation, documentation, evaluation, and resolution of a claim handled by VFIS Claims Management. This authorization expires upon the final adjudication of the claim identified above or two years from the date below, whichever is earlier.

This authorization may be revoked in writing at any time by notifying VFIS Claims Management.

No health care provider may condition treatment or the receipt of any benefits upon the signature of this authorization.

A photostatic copy of this authorization shall be considered as valid as the original.

The information disclosed under this authorization may no longer be protected by C.F.R. Parts 160 and 164 (HIPAA Privacy Rule) and may be re-disclosed by the recipient.

_____ _____

Signature of Named Patient or Authorized Legal Representative Date

_____

Printed Name of Named Patient or Authorized Legal Representative

_____

Description of Authorized Legal Representative's Authority