ACCIDENT/SICKNESS CLAIM REPORT

Please Complete and Mail to:

Downey Public Risk Underwriters
Toll Free (800)382-8837
Fax (765)868-3310

PLEASE COMPLETE THIS FORM IN FULL FOR PROMPT SERVICE

NOTE: Important State Information Included

DATE OF THIS REPORT ______________

SECTION 1 – CLAIMANT INFORMATION

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) ________________________

Date of Incident or Organization's Activity ____________________ Year _________ Time________ ☐ AM ☐ PM

Full-Time/Regular Occupation ________________________ Annual Income ____________

Name/Address of Full-time Employer ________________________________

Length of Employment in this Work ________________ Employer's Phone Number ________________

SECTION 2 – INCIDENT AND MEDICAL TREATMENT INFORMATION

1. What activity was the individual above involved in at the time of their injury or illness?

2. How did the injury or illness occur?

3. Please describe the injury or illness.

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

SECTION 3 – AUTHORIZATION TO DOCTOR, HOSPITAL, CLINIC, EMPLOYER, INSURANCE COMPANY OR WORKERS' COMPENSATION CARRIER TO RELEASE MEDICAL INFORMATION

I authorize any Health Care Provider, Employer, Insurance Company, Workers' Compensation Carrier, Person or Organization to release information regarding my medical history, treatment, earnings, or benefits payable, including disability or employment related information, to Glatfelter Claims Management Inc., for the purpose of determining benefits that may be payable under the VFIS Accident and Sickness (A&S) policy. If medical benefits are determined to be payable under the VFIS A&S policy, I authorize payment to be made directly to my medical provider(s). 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   Date

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 above described incident? ☐ Yes ☐ No
- If claimant is a member of organization, please select type of member: ☐ Junior ☐ Adult ☐ Auxiliary
- Was the activity described in #1 above an authorized activity of the named insured organization? ☐ Yes ☐ No
- **Name and Address of Organization**

____
____
____

- Policy Number ______________
- Organization Telephone Number ______________
- Home Telephone Number of Official Signing Below ______________

I certify that the above is true.

Signed ________________________ Title________________ Date ____________

Print Name ________________________

ATTENDING PHYSICIAN'S STATEMENT

Please Complete and Mail To:

Downey Public Risk Underwriters
Toll Free (800)382-8837
Fax (765)868-3310

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NOTE: SEE ENCLOSED SHEET FOR IMPORTANT STATE INFORMATION.

Name of Patient ______________________________ DOB __________

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

The above named individual has filed a claim for benefits as a result of the Injury/Illness for which he/she 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.

(1) Diagnosis and concurrent conditions (If fracture or dislocation, describe nature and location, If Sickness / Illness describe nature).

(2A) When did symptoms first appear or accident happen? Date __________

(B) When did patient consult you for this condition? Date __________

(C) Has patient ever had same or similar condition? (If Yes, state when and describe) Yes No

(3A) Nature of surgical procedure, If Any (Describe Fully) - Date Performed __________ Inpatient Outtpatient

(B) If performed in hospital, give name and address:

(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 due to diagnosis in #1 above?
(Unable to perform Regular Occupation) From Date __________ Through __________

(B) How long was or will patient be partially disabled? From Date __________ Through __________

(C) Approximate date patient will return to work if still disabled Date __________

(7) Restrictions:

Date __________ Signature ______________________________
(attending physician) (degree) (telephone no.)

Address ______________________________