

ACCIDENT/SICKNESS CLAIM REPORT

Please Complete and Send To:

**PLEASE COMPLETE THIS FORM
IN FULL FOR PROMPT SERVICE.**



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

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 _____

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? Yes _____ No _____ Year _____
(If Yes, State When and Describe)

(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 _____

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