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

Home Telephone No. (AC)____________
Work Telephone No. (AC)____________
Name____________________________ Soc. Sec. No.____________

Home Address____________________ City________ State______ Zip______

Date of Accident or Organization's Activity____________ Year: ____ Occurred________ am 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 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?
(If Yes, State When and Describe) Yes ______ No ______

(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 ______ ______ Year

(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 ______

A01:002 (Rev. 11/03)