ACCIDENT/SICKNESS CLAIM REPORT

Please Complete and Mail To:

PLEASE COMPLETE THIS FORM IN FULL FOR PROMPT SERVICE.

VFIS of Texas
3420 Executive Center Drive, Suite 301
Austin, TX 78731-1626
Phone (800) 252-9435 Fax (512) 448-9929

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 ______________

Item No. A:01:001 (01/03)