ACCIDENT/SICKNESS CLAIM REPORT

Please Complete and Mail to:

PRU - Midwest
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 (___) _____ Work Phone (___) _____ Cell 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 OR WORKERS' COMPENSATION CARRIER TO RELEASE MEDICAL INFORMATION

Please furnish Glatfelter Claims Management, Inc. with information or documentation they may request regarding details of the medical history and physical condition, current course of medical treatment or workers' compensation claim for the individual identified above. 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

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 _____

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 Sates

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.

ATTENDING PHYSICIAN'S STATEMENT

Please Complete and Send To:

Public Risk Underwriters of the Midwest
Toll Free (800)382-8837
Fax (765)868-3310

PLEASE COMPLETE THIS FORM IN FULL FOR PROMPT SERVICE.

NOTE: IMPORTANT STATE INFORMATION ON REVERSE SIDE

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 _____ _____

(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