ACCIDENT/SICKNESS CLAIM REPORT

Please Complete and Mail to:

VFIS
A Division of Glatfelter Insurance Group

Glatfelter Claims Management, Inc.
P.O. Box 5126, York, PA 17405-9792
(800) 233-1957, Fax: (717)747-7051

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**

York County Rural Fire Program
PO Box 82
York, SC 29745-0082

- Policy Number _____
- Organization Telephone Number (803) 620-2270
- Home Telephone Number of Official Signing Below _____

I certify that the above is true.

Signed _____ Title _____ Date _____