

This form must be returned **to the School within 90 days from the date of incident.**
 VACORP will send parents information on submitting bills and EOBs for consideration on applicable claims (*School will not accept bills or EOB documentation*).



**STUDENT
 ACCIDENT CLAIM
 FORM**

Student Accident Coverage is SECONDARY to any other insurance, including Medicaid, FAMIS, or private health insurance.

PART 1: INCIDENT INFORMATION (TO BE COMPLETED BY THE SCHOOL)

School Division: _____
 School Name: _____
 School Address: _____
 Student's Name: _____

Male Female Date of Injury: _____ Date of Birth: _____

Grade Level: _____
 Body Part: _____

Description of Accident (Include an additional page if needed):

If Athletics, please indicate the sport: _____

At the time of injury, was the student involved in a School Division sponsored activity? Yes No

Under whose supervision? _____ Phone #: _____

Signature of Preparer: _____ Title: _____
 Printed Name: _____ Date: _____ Phone #: _____

PART 2: PARENT INFORMATION (TO BE COMPLETED BY THE PARENT, PLEASE INCLUDE BOTH STUDENT AND PARENT INFORMATION)

Student Information:
 Student Address: _____

Parent Information:
 Father's Name: _____ Phone #: _____
 Father's Employer: _____
 Employer's Address: _____
 Mother's Name: _____ Phone #: _____
 Mother's Employer: _____
 Employer's Address: _____

Please list **ALL** insurance policies: _____ Check if No Insurance

Name of Insurer: _____
 Address: _____ Policy #: _____
 Phone #: _____ Group Individual

Treatment Information:
 Physician/ Facility Name: _____
 Address of Physician/ Facility: _____
 Phone #: _____ Date Seen By Physician/ Facility: _____

Instructions:

In case of an accident, notify the school immediately.

1. Complete this claim form and return it to the school within 90 days from the date of injury.
2. Please include information on any available health care insurance, including Medicaid.
3. In order to process this claim for payment, VACORP will need itemized bills and all Explanations of Benefits (EOB) showing what your insurance has paid. Statements without itemized information will not be accepted.
4. When you receive your EOB, send it to VACORP, along with the corresponding itemized statements. We will pay benefits for eligible expenses per the terms of the contract.
5. Benefits are paid directly to the providers of service unless VACORP receives paid receipts.

Student Accident coverage is only available to cover students for accidental injury occurring while the contract is in force.

Benefits are provided on a **SECONDARY** excess basis for covered expenses **incurred and reported** within one year after the date of the accident.

Benefits are payable up to the applicable maximum for the covered expenses that are in excess of other valid and collectible insurance including: Medicaid, Medicare, FAMIS and private health insurance.

This claim form must be submitted to VACORP by the school division prior to any bills being reviewed or processed.

If your medical coverage is under an HMO, PPO or similar plan, you must follow their requirements for obtaining benefits; otherwise, VACORP's benefits may be reduced, where applicable, as stated in the contract provisions.

AUTHORIZATION FOR RELEASE OF INFORMATION: I AUTHORIZE any physician, medical care provider, hospital, clinic, medical care facility, insurance company, government-sponsored health plan, or employee having information available as to diagnosis, treatment and prognosis with respect to any illness, injury, physical or mental condition, and/or treatment for me or my minor children now or in the past, to give to VACO Group Self-Insurance Risk Pool (VACORP) or its legal representative, any and all such information.

I UNDERSTAND the information obtained will be used by VACORP to determine eligibility for insurance and eligibility for benefits under any existing policy. Any information obtained will not be released by VACORP to any person or organization except as necessary in connection with the processing of this application, claim or as may be otherwise lawfully required or as I may further authorize. I further understand that I may request to receive a copy of this Authorization.

I AGREE that a photographic copy of this Authorization shall be as valid as the original. I also AGREE this Authorization shall be valid for a period of two years from the date shown below. I may revoke this authorization at any time by written request to VACORP.

I CERTIFY that the information given by me in support of this claim is true and correct.

Any payment will be made to the service provider (hospital, physician, and others) unless a paid receipt or statement accompanies the bill when the claim is submitted to VACORP.

AFFIDAVIT: I verify that the statement in Part 2 about other insurance is accurate and complete. I understand that the intentional furnishing of incorrect information via US Mail may be fraudulent and violate federal and state laws. I agree that if it is determined at a later date that there are other insurance benefits collectible on this claim, I will reimburse VACORP to the extent VACORP made a payment for which it was not obligated under the contract.

Parent or Authorized Representative's Signature: _____ Date: _____

If Authorized Representative, Relationship to Student or Legal Designation: _____