This form must be returned **to the School within 180 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*).

VACORP
(888) 822-6772

Catastrophic Student Accident Claim Form

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

Please select one of the following: ☐ **Fatality** ☐ **Catastrophic Claim**

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

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

☐ Male ☐ Female Date of Injury/Fatality _____ 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: _____

Name and addresses of doctors attending the deceased following the accident:
Doctor: _____ Address: _____
Doctor: _____ Address: _____
Doctor: _____ Address: _____
Doctor: _____ Address: _____

Was this accident reported to the police department? ☐ Yes ☐ No If yes, indicate the name of the police department _____

Was an autopsy held? ☐ Yes ☐ No If so, who conducted the autopsy (Name and address):

Did the deceased have any chronic disease, physical defects or deformities? ☐Yes ☐ No If yes, please describe:

Instructions:
In case of an accident, notify the school immediately.

1. Complete this claim form and return it to the school within 180 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.

Required:

Please attach a copy of the death certificate to this form once the form has been completed and is ready to be returned to VACORP.

Note – only a copy is required and not a certified death certificate.

AUTHORIZATION FOR RELEASE OF INFORMATION: I hereby authorize all medical service sources and health care providers to disclose a complete copy of my health records, including records related to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse to Virginia Association of Counties Group Self-Insurance Risk Pool, its subsidiaries and affiliates, its claim associates, and legal representatives (hereinafter referred to collectively as VACORP).

I authorize the use of the above information for VACORP to investigate, process and determine the amount payable, if any, for all claims made under any VACORP property and casualty contract that applies to the accident or occurrence on _____. I understand as part of the claim handling process, VACORP may disclose medical or other information obtained by this authorization to physicians, dentists, other medical or healthcare providers or other professional for their review and professional opinion. This information may also be released to other insurance companies for their use in connection with insurance transactions, or as required or permitted by law. Information obtained pursuant to this authorization may later be redisclosed and may not be

protected under the HIPAA privacy rule. I understand that I may refuse to authorize disclosure of all or some of the requested information, but that refusal may potentially cause a delay in processing, or result in the denial of, insurance benefits for the pending injury claim(s).

This authorization may be revoked at any time, except to the extent that VACORP has taken action in reliance on this authorization prior to notice of revocation. Such revocation must be in writing, dated, signed, and include the claim number referenced above. I understand that revocation of this authorization may potentially cause a delay in processing, or result in the denial of, insurance benefits for the pending injury claim(s). This authorization is valid for the duration of the claim referenced above, and a photocopy is as valid as the original. This authorization specifically applies to records made before, during, and after the date of signing this authorization for as long as the authorization is in effect.

I have read the authorization and singed this document. I verify that the statement in Part 2 about other insurance is accurate and complete. 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. It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

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.

Parent or Authorized Representative's Signature:_____ Date _____

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