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

VACORP

(888)822-6772

STUDENT ACCIDENT CLAIM FORM

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

PART 1: INCIDENT INFORMATION

School Division: _____

School Name: _____

School Address: _____

Student's Name: _____ Date of Birth: _____

Male or Female (circle one) Date of Injury: _____ Time of Injury: _____

Grade Level: _____ Injury Sustained: _____

Description of Accident (Include add'l 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 # _____

Website Assigned Claim Number: _____

Signature: _____ Title: _____ Date: _____

Printed Name: _____ Phone #: _____

PART 2: PARENT INFORMATION

Provide 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: _____ ☐ Group Policy No. _____

Phone #: ☐ Individual Policy No.

CLAIM INSTRUCTIONS

In case of 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 Explanation 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 U.S. 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: _____