This form must be returned **to the school division within 90 days from date of incident.** The school division will not accept bills or EOBs. VAcorp will send parent/guardian information on submitting bills and EOBs for consideration on applicable claims.

Catastrophic or Fatality Claim Form

(888) 822-6772

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

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

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: ____________________ Diagnosis: ____________________

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

____

____

Please indicate the sport in which the student was participating at the time of incident:

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 of Preparer: ____________________ Title: ____________________
Printed Name: ____________________ Date: ____________________ Phone #: ____________________

PART 2: PARENT INFORMATION (TO BE COMPLETED BY THE PARENT, PLEASE INCLUDE BOTH *STUDENT* AND *PARENT* INFORMATION) *If additional room is needed, please feel free to use another piece of paper*

Student Information:
Student Address: ____________________ Student SSN: _____-_____-______

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: ☐ Medicare/Medicaid ☐ Check if No Insurance

Name of Insurer (1): ____________________
Address: ____________________
Policy #: ____________________ HICN (If Medicare): ____________________
Phone #: ____________________ ☐ Group ☐ Individual Name of Policy Holder: ____________________
Name of Insurer (2): ____________________
Address: ____________________ Policy #: ____________________
Policy #: ____________________ HICN (If Medicare): ____________________
Phone #: ____________________ ☐ Group ☐ Individual Name of Policy Holder: ____________________

Updated 10-31-24

Treatment Information: **Names and addresses of doctors attending the student following the accident:**
Physician/ Facility Name (1): ____________________
Address of Physician/ Facility: ____________________
Phone #: ____________________ Date Seen By Physician/ Facility: ____________________

Physician/ Facility Name (2): ____________________
Address of Physician/ Facility: ____________________
Phone #: ____________________ Date Seen By Physician/ Facility: ____________________

Physician/ Facility Name (3): ____________________
Address of Physician/ Facility: ____________________
Phone #: ____________________ Date Seen By Physician/ Facility: ____________________

If fatality, was an autopsy conducted? ☐ 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.
VHSL Catastrophic coverage is only available to cover students for accidental injury occurring while participating in VHSL activities and while this Contract is in force.

1. Complete this claim form, sign, and return it to the school division within 90 days of the date of injury. This claim form must be submitted to VAcorp by the school division prior to any bills being reviewed or processed. **If the claim form is submitted to VAcorp after 90 days of the date of injury, the claim will not be considered for payment.**
2. 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.
3. When you receive an EOB, send it to VAcorp, along with the corresponding itemized statements. We will pay benefits for eligible expenses per the terms of the Contract.
4. If the incident resulted in a fatality, please attach a copy of the death certificate to this form. Only a copy of the death certificate is required, not a certified certificate.
5. VAcorp will not issue payment on any claim until the claimant's Social Security Number and Date of Birth are provided per MMSEA guidelines. In lieu of a SSN, a Medicare Health Insurance Claim Number (HICN) may be submitted.
6. All claims are subject to the terms, conditions, and exclusions found in the coverage document. The coverage contract supersedes any contradictory statements contained herein.

The **Fund** will pay the **Medical Expenses** a **Covered Person** incurs that exceed amounts payable by any **Other Insurance Plan**, subject to the Deductible, Benefit Percentage, and **Benefit Period** shown on the Schedule. The **Fund** will determine the amount of benefits provided by any **Other Insurance Plan** without reference to any coordination of benefits, non-duplication of benefits, or similar provisions. The amount of benefits provided by an **Other Insurance Plan** includes any amount to which the **Covered Person** is entitled whether or not a claim is made for the benefits. This Contract is secondary to all **Other Insurance Plans**.

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 that, 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 professionals 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 signed 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: ____________________________________