

Submit this form one of the following ways:

Email: tech1@riskprograms.com
Mail: VACORP, Attn. VASC Claim
1819 Electric Rd., Suite C
Roanoke, Virginia 24018



VACORP

Volunteer Accident and Sickness Coverage

Questions

888-822-6772

Please Note it will take up to 2 business days before the adjuster will have the claim available

Notice of Claim for Volunteer Accident and Sickness Coverage
Medical and Disability Benefits

Please complete this claim form and return it to us within 30 days from the date of injury/illness.

Member Name:		
Volunteer Organization Name:		
Volunteer Organization Address:		Volunteer Organization Phone Number:
Date of Event:		
Event Description:		
Claim Filed: <input type="checkbox"/> Medical	<input type="checkbox"/> Disability	<input type="checkbox"/> Both
Volunteer Name:		
Volunteer Address:		
Volunteer Phone:	Volunteer Email:	
Volunteer Date of Birth:	Volunteer SSN:	
Volunteer Employed Elsewhere (check box that applies): <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, Employer Name and Phone Number:		Is Volunteer able to work? (paid job): <input type="checkbox"/> Yes <input type="checkbox"/> No
Injured Body Part(s):		
Have you had this injury/illness/condition previously? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Date injury/illness first commenced:		
Nature of injury/illness:		

I certify that the information given by me in support of this claim and the injury and/or sickness information provided on this form to be true and accurate to the best of my knowledge. It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, and denial of insurance benefits.

Volunteer Signature: _____ Date: _____

Printed Name of Commanding Officer/Supervisor:	
Title of Commanding Officer/Supervisor:	Phone Number:

I hereby certify that volunteer is a member of the group insured under the above policy and the injury/sickness was sustained under adequate supervision while participating in an official covered activity.

Signature of Commanding Officer/Supervisor: _____ Date: _____