Submit this form one of the following ways:

Email: Attach and send to **tech1@vacoins.org**

Mail: VACORP, Attn. VASC Claim
1315 Franklin Rd, SW
Roanoke, Virginia 24016

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: ☐ Medical	☐ Disability	☐ Both
Volunteer Name:		
Volunteer Address:		
Volunteer Phone:	Volunteer Email:	
Volunteer Date of Birth:	Volunteer SSN:	
Volunteer Employed Elsewhere (check box that applies): ☐ Yes ☐ No		
If yes, Employer Name and Phone Number:		Is Volunteer able to work? (paid job): ☐ Yes ☐ No
Injured Body Part(s):		
Have you had this injury/illness/condition previously? ☐ Yes ☐ 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:_____