VFIS®
A Division of Glatfelter Insurance Group®

A Tradition of Service. Founded on Trust.

Dear Valued Client:

Thank you for selecting the VFIS Accident and Sickness Program. The coverage is intended to provide financial security to your members and their families in the event of an injury or illness occurring while performing normal duties of your organization.

It is unfortunate that tens of thousands of emergency service personnel suffer disabling injuries each year. VFIS is committed to identifying patterns associated with these injuries and developing programs which can help reduce the frequency and severity of these incidents.

As a VFIS insured, the majority of our Education, Training and Risk Control programs are available to you at no charge. I encourage you to view all of our programs at our website, www.vfis.com.

Attached you will find beneficiary forms and a beneficiary poster. We request that you review the beneficiary selections with your covered individuals and use these forms to update any current records that are outdated. Marriages, divorces and deaths can affect beneficiary selections and a periodic review, at least every few years, is very important. **The completed forms should be kept on file at your department,** so that if beneficiary changes are necessary, the forms are readily available. The beneficiary poster is intended to provide a reminder about the importance of updating beneficiary cards. The poster is small enough to be displayed on a bulletin board in the station.

Also attached are claims forms and a claim service guide to help you administer your Accident & Sickness program. For more on our risk management programs, as well as additional resources available for download, visit www.VFIS.com.

I know we share the mutual goal of keeping your emergency service personnel safe and injury free. We believe using these programs will be a positive step. We encourage you to take advantage of our programs and forms. If you require additional assistance, please contact your insurance agent or VFIS Risk Control Services at (800) 233-1957.

Sincerely,

Troy Markel

Todd W. Thompson

Troy Markel, CIC, CRM
President VFIS

Todd W. Thompson, ALCM, MSS
Senior Vice President, Risk Control Services

183 Leader Heights Road • P.O. Box 2726 • York, Pennsylvania 17405
(717) 741-0911 • (800) 233-1957 • Fax (717) 747-7020 • www.vfis.com

Introduction

On behalf of VFIS and your agent, thank you for placing your trust and business with VFIS. We intend to provide the most comprehensive and professional insurance services available.

A vital first step in the successful handling of a claim is prompt and accurate notification to us of your claim. By providing timely, relevant information concerning your organization's claim, you will assist us in serving your claim needs.

It is our hope that you will never experience the inconvenience of a claim. If you do, you have our resources, experience, and knowledge to rely upon.

ACCIDENT & SICKNESS CLAIMS

A. NON-FATAL CLAIMS-All non-fatal claims should be reported directly to your agent's office as soon as possible.

To process these claims, please provide the following information:

1. Completed Accident Report (These forms are provided with the policy and additional forms will be provided upon request), which includes the following:

   a. The top section must be completed and signed by the injured person, giving a clear description of the activity and circumstances surrounding the injury.
   b. The bottom section must be completed by a fire company official (other than the injured person), certifying that the information on the report is true.

2. Confirmation of disability by the attending physician. If disability persists, confirmation will be required approximately once a month. Ongoing disability payments are made once every two weeks as disability is confirmed. Wage verification will be needed if disability persists longer than 30 days.

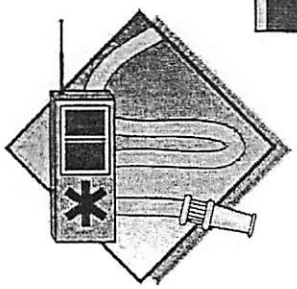
B. FATAL CLAIMS-**ALL FATAL CLAIMS SHOULD BE REPORTED IMMEDIATELY BY PHONE TO US.** In addition, please notify your agent's office.

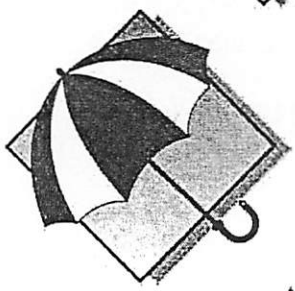
To process these claims, please provide the following information:

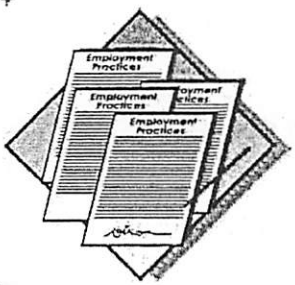
1. Completed Accident Report signed by next of kin
2. Statement of fire officer in charge
3. Copy of fire company log
4. Beneficiary card or letter from Secretary of the insured organization stating that there is no beneficiary card
5. Death Certificate (certified copy)
6. Autopsy report and/or hospital records (if available, if not we will obtain these items)
7. Police report and newspaper articles (if available)

This guide references policies that are underwritten by National Union Fire Insurance Company of Pittsburgh, PA.

P.O. Box 5126 • York, Pennsylvania 17405
(717) 741-0911 • (800) 233-1957 • Fax: (717) 747-7051 • www.vfis.com







VFIS®

A Division of Glatfelter Insurance Group

Accident & Sickness Claim Service Guide for Insureds and Agents

A01:111AS (3/09)

ACCIDENT/SICKNESS CLAIM REPORT

Please Complete and Mail To:

VFIS
A Division of Glatfelter Insurance Group

VFIS
P.O. Box 5126, York, Pennsylvania 17405-9726
Call (717) 741-0911 · Toll Free: (800) 233-1957
Fax (717) 747-7051

PLEASE COMPLETE THIS FORM IN FULL FOR PROMPT SERVICE.

NOTE: IMPORTANT STATE INFORMATION ON REVERSE SIDE

DATE OF THIS REPORT_____

TO BE COMPLETED BY INJURED PERSON

Home Telephone No. (AC)_____
Work Telephone No. (AC)_____
Name_____ Soc. Sec. No._____

Home Address_____ City_____ State_____ Zip_____

Date of Accident or Organization's Activity_____ Year: _____ Occurred_____ am pm
Date of Birth_____ Sex_____ Weight_____ Height_____ Marital Status_____
Full-Time/Regular Occupation_____ Income: Weekly_____ Yearly_____
Name and address of full-time employer_____

Employer Telephone No.:_____ Length of employment in this work:_____

Please completely answer the next three questions:

1. What activity were you involved in when injured or became ill?

2. How did accident or sickness occur?

3. What is your injury or sickness?

Give date of first day of full-time occupation missed due to above accident and sickness _____
Give date you were able to return to work _____
Attending Physician's Name, Address and Telephone Number _____

Name and Address of Hospital _____ Dates Hospitalized
From _____ _____ Year
To _____ _____ Year

AUTHORIZATION TO DOCTOR, HOSPITAL, CLINIC, OR WORKERS' COMPENSATION CARRIER TO RELEASE MEDICAL INFORMATION

Please furnish VFIS, Inc. with information they may request regarding details of my past medical history and physical condition. A photostatic copy of this authorization shall be considered as valid as the original. Your help is greatly appreciated.

Signature of Injured Member or Next of Kin _____ Relationship _____ Date _____

TO BE COMPLETED BY OFFICIAL OF NAMED INSURED ORGANIZATION (must be other than Injured Person)

- Was the injured person a member of your organization at the time of the above described incident? Yes No
- If claimant is a member of organization, please circle type of member: junior adult auxiliary (Circle one)
- Was the injured person engaged in an authorized activity of your organization at the time of injury or commencement of sickness? Yes No
- Name and Address of Insured Organization
- Policy Number_____
- Organization Telephone Number_____
- Home Telephone Number of Official Signing Below_____

I certify that the above is true.

• Signed _____ • Title _____ • Date _____

Applicable in Pennsylvania

Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material hereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Applicable in New York

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Applicable in California

For your protection, California law requires the following to appear in this form:
Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Applicable in all other states

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

VFIS®

Beneficiary Designation for Accident & Sickness Policy

Complete this block each time this form is used—Please Print

Name of Organization _____ State _____

Member's /Employee's Name _____

Member's Date of Birth _____ Date Member Joined Organization _____

Complete, sign and date this block if you wish to name or change your beneficiary.

I hereby designate the following beneficiary(ies) with respect to amounts payable as indemnity for loss of life under the referenced Accident & Sickness Policy and hereby revoke any designation of beneficiary thereunder heretofore made by me. I direct that any amounts payable under said policy to my beneficiary(ies) named below be paid to those of Primary Beneficiary who survive me, otherwise to those surviving in Contingent Beneficiary, in proportion to the percentages listed.

Primary (Please refer to back of form for examples)
Beneficiary: Name _____ Relationship _____ Date of Birth_____ Share_____%

Name _____ Relationship _____ Date of Birth_____ Share_____%

Contingent
Beneficiary: Name _____ Relationship _____ Date of Birth_____ Share_____%

Name _____ Relationship _____ Date of Birth_____ Share_____%

If none of the above-named beneficiaries are living at the time of my death, I direct that payment be made in accordance with the terms of the policy. I reserve the right to revoke or change this designation.

Signature_____ **Date** _____

This form should be retained in the files of your department or organization and reviewed and updated on a regular basis.

Specifying Beneficiaries

Individual (always show relationship to the Insured)	***Primary Beneficiary**	****Contingent Beneficiary**	Second **Contingent Beneficiary**
One Beneficiary	Jane Ann Jones, wife, 100%	(leave blank)	(leave blank)
One Primary Beneficiary and one Contingent Beneficiary	Jane Ann Jones, wife, 100%	David Lee Jones, son, 100%	(leave blank)
Two primary beneficiaries and one contingent beneficiary	Arthur Leo Jones, father, 50% Grace Hays Jones, mother 50%	Marie Jones Ford, sister, 100%	(leave blank)
One Primary Beneficiary, unnamed children as first Contingent Beneficiary and two second Contingent Beneficiaries	Jane Ann Jones, wife, 100%	Children born of my marriage to Jane Ann Jones, to share equally	Arthur Leo Jones, father, 50% Grace Hays Jones, mother, 50%
Unequal distribution (always use percentages)	Grace Hays Jones, mother, 50% Mary Jones Ford, sister, 25% William Roger Jones, brother, 25%	Surviving Primary Beneficiaries share equally in the portion designated for any Beneficiary(ies) who predeceases the insured	(leave blank)
Insured's Estate	Executors, Administrators or Assigns of the Insured	(leave blank)	(leave blank)

* Primary Beneficiary is the person(s) who will receive the insurance proceeds.

** Contingent Beneficiary is the person(s) who will receive the insurance proceeds if the primary beneficiary is not alive at your death.