AmeriCorps VISTA

Injury and Accident Form

POWERED BY IMG

If you were involved in an accidental injury during your VISTA volunteer service, please complete the following form. If the IMG claims department is requesting this form, then we have already received medical bills which indicate you may have been involved in an accident.
We need the following information from you to complete our file prior to the possible payment of your claims.

The completed form and any other necessary documents can be submitted by secure means to IMG at:
E-mail*: **VISTAcare@imglobal.com** Fax: **(855) 851-2971**
Postal Mail: **International Medical Group ATTN: AmeriCorps VISTA Claims, P.O. Box 550, Farmington Hills, MI 48332**
If you have any questions, please call IMG at **(855) 851-2974** or **(317) 833-1711**

General Information

Full Legal Name: *(Last, First, Middle)*	
Date of Birth: __/__/__ (MM/DD/YY)	Date of Service: __/__/__ (MM/DD/YY)
Member ID Number: *(Located on your ID card)*	IMG Claim Number: *(If known)*

Part 1

Please describe how, when and where your injury / accident occurred: *(You may provide additional sheets if necessary)*

List all the names and addresses of the providers seen as a result of this Injury or Accident:

Was this condition the result of an accident or injury:

a. Related to your service with AmeriCorps? ☐ Yes ☐ No

b. Involving a motor vehicle? ☐ Yes ☐ No

If yes, please list the names of involved parties, insurance carriers, policy numbers and a claim number:

c. Was a police report filed? ☐ Yes ☐ No

If yes, please submit a copy of the police report along with this form

Part 2

Are you pursuing a claim against any other party? For instance, the owner of the premises where you were injured. ☐ Yes ☐ No

If yes, please provide the name and address of the other party(ies):

Name and Address of Other Party:

City:	State/Country:	Postal/Zip Code:

Part 3

If legal counsel is representing you against other parties, please provide the name, address and phone number of your legal counsel.

☐ Not Applicable

Address of Legal Counsel:

Clty:	State/Country:	Postal/Zip Code:

Signature

Member Signature: X _____	Date: __/__/__ (MM/DD/YY)

**Notice on Electronic Communication and Privacy: Please submit these documents via secure means, such as encrypted email or by fax. If you choose to send the information via unsecure email, you are solely responsible for any subsequent data breach or data loss caused by your decision. To protect your private information, we recommend you consider using any secure or confidential/encrypted email sending options with your email service provider. You may also consider password protecting your documents and sending the password in a separate email.*

***If another party was involved in this accident and is liable for payment of injuries, AmeriCorps VISTA will subrogate your claim. Subrogation entitles AmeriCorps VISTA to a refund of benefits paid out of any recovery from a third party, its insurer, or uninsured motorist insurance and allows AmeriCorps VISTA to file a lien or have a lien upon any recovery you receive. Please accept this correspondence as notice of our lien in this matter. No settlement with any party is complete without the indemnification of AmeriCorps VISTA.*

We are required by the Privacy Act of 1974 (5 U.S.C. 552a) to tell you what personal information we collect and how it will be used: Authorities – This information is requested pursuant to 42 U.S.C. 4955, Support services; 42 U.S.C. 12618, Authorized benefits for Corps members; and 45 CFR § 2556.320 - What benefits may a VISTA receive during VISTA service? Purposes – It is requested to manage and evaluate the health benefits programs offered to VISTA, NCCC, and FEMA Corps Members. Routine Uses – Routine uses of this information may include disclosure to (1) health care providers and insurance companies to provide care and coordinate payment, (2) contractors to assist with providing the health care benefit, and (3) federal, state, or local agencies pursuant to lawfully authorized requests. Effects of Nondisclosure – This request is voluntary, but not providing the information will likely affect your ability to receive your health care benefits.

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