PERSONAL ACCIDENT (Accident & Sickness)
Policy # 00206210272

CLAIM FORM
Please answer all questions in order to expedite processing.

Send claims to: Adventist Risk Management
12501 Old Columbia Pike
Silver Spring, MD 20904

(O): +1 (301) 680.6870
(F): +1 (301) 680.6878
(E): claims@adventistrisk.org

Program: **INTERNATIONAL CAMPERS PROGRAM** **Option Elected:** _____

INSTRUCTIONS:

1. You must have SECTION A fully completed by a designated official of the Policyholder
2. SECTION B is to be completed, signed and dated by the claimant or parent/guardian of claimant, if claimant is a minor.
3. Attach itemized bills for all medical expenses being claimed including the claimant's name, condition being treated (diagnosis), description of services, date of service(s) and the charge made for each service. PLEASE MAIL COMPLETED FORM AND BILLS TO ABOVE ADDRESS.

SECTION A – MUST BE COMPLETED AND SIGNED BY A DESIGNATED REPRESENTATIVE OF THE POLICYHOLDER

NAME/ AND/OR LOCATION OF GROUP/CLUB/SPORT/SCHOOL, ETC.

CLAIMANT'S FULL NAME (PLEASE PRINT CLEARLY OR TYPE)	SOCIAL SECURITY # (IF AVAILABLE)	DATE OF BIRTH	NAME OF SUPERVISOR

DATE COVERAGE BEGAN MO DA YR	DATE COVERAGE WILL END/HAS ENDED MO DA YR

DESCRIPTION OF LOSS

DATE OF LOSS MO DA YR	TIME OF LOSS ☐ AM ☐ PM

CITY IN WHICH LOSS OCCURRED	COUNTRY

DID ACCIDENT OCCUR

A.	WHILE CLAIMANT WAS SUPERVISED?	☐ YES	☐ NO
B.	DURING SPONSORED ACTIVITY?	☐ YES	☐ NO
C.	DURING PROGRAM HOURS?	☐ YES	☐ NO
D.	WHILE TRAVELING TO OR FROM REGULARLY SCHEDULED ACTIVITY IN A SUPERVISED GROUP?	☐ YES	☐ NO

DATE LAST WORKED MO DA YR	DATE RETURNED TO WORK MO DA YR

POLICYHOLDER REPRESENTATIVE (PLEASE PRINT OR TYPE)	TITLE	DAYTIME TELEPHONE NUMBER ( )

SIGNATURE OF POLICYHOLDER REPRESENTATIVE	DATE MO DA YR

SECTION B – MUST BE COMPLETED

LIST NAME, ADDRESS, AND PHONE # OF OTHER INSURANCE COMPANIES UNDER WHICH CLAIMANT IS INSURED:	POLICY #/ACCOUNT #

IF CLAIMANT IS A MINOR, NAME OF CLAIMANT'S GUARDIAN/RELATIONSHIP TO CLAIMANT

ADDRESS OF CLAIMANT (IF CLAIMANT IS A MINOR, NAME AND ADDRESS OF CLAIMANT'S GUARDIAN)	GUARDIAN'S SOCIAL SECURITY #

CITY	STATE	ZIP	COUNTRY

EMPLOYER NAME (IF CLAIMANT IS A MINOR, GUARDIAN'S EMPLOYER NAME)	EMPLOYER'S DAYTIME TELEPHONE # ( )

EMPLOYER ADDRESS (IF CLAIMANT IS A MINOR, GUARDIAN'S EMPLOYER ADDRESS)

CITY	STATE	ZIP	COUNTRY

☐ **I HEARBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.**

AUTHORIZATION AND ASSIGNMENT OF BENEFITS

I, the undersigned authorize any hospital or other medical-care institution, physician or other medical professional, pharmacy, insurance support organization, governmental agency, group policyholder, insurance company, association, employer or benefit plan administrator to furnish to the Insurance Company named above or its representatives, any and all information with respect to any injury or sickness suffered by, the medical history of, or any consultation, prescription or treatment provided to, the person whose death, injury, sickness or loss is the basis of claim and copies of all of that person's hospital or medical records, including information relating to mental illness and use of drugs and alcohol, to determine eligibility for benefit payments under the Policy Number identified above. I authorize the group policyholder, employer or benefit plan administrator to provide the Insurance Company named above with financial and employment-related information. I understand that this authorization is valid for the term of coverage of the Policy identified above and that a copy of this authorization shall be considered as valid as the original. I understand that I or my authorized representative may request a copy of this authorization.

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE PHYSICIAN OR SUPPLIER FOR SERVICE PERFORMED. ☐ **YES** ☐ **NO**

CLAIMANT OR AUTHORIZED PERSON'S SIGNATURE	DATE MO DA YR

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COVERED LOSSES (Please check all that apply)

☐ **Part I.** **ACCIDENTAL DEATH & DISMEMBERMENT/PERMANENT TOTAL DISABILITY**

ARE YOU TOTALLY DISABLED? ☐ YES ☐ NO

IS IT A DIRECT RESULT OF THIS ACCIDENT? ☐ YES ☐ NO

NAME AND CONTACT DETAILS OF ANY WITNESS(ES):

FULL NAME: _____ FULL NAME: _____

EMAIL: _____ EMAIL: _____

PHONE #: _____ PHONE #: _____

HAVE YOU SUFFERED FROM THE SAME CONDITION BEFORE? ☐ YES ☐ NO

IF YES, PLEASE PROVIDE THE FOLLOWING

1. DATE OF CONSULTATION Mo _____ DA _____ YR _____
2. NAME AND ADDRESS OF DOCTOR CONSULTED

FULL NAME: _____

ADDRESS: _____

NAME AND ADDRESS OF YOUR PRIMARY DOCTOR:

FULL NAME: _____

ADDRESS: _____

PLEASE ATTACH THE FOLLOWING TO THIS CLAIM FORM:

☐ COPY OF DEATH CERTIFICATE
☐ COPY OF AUTOPSY REPORT
☐ ADDITIONAL INFO

☐ **Part II.** **ACCIDENT OR SICKNESS MEDICAL EXPENSE(S)**

LOSS DUE TO:

☐ ACCIDENT
☐ DREAD DISEASE
- ☐ POLIO LEUKEMIA
- ☐ TULAREMIA

☐ OTHER SICKNESS

MORE INFO: _____

IF SO, PLEASE CHECK WHICH OF THE FOLLOWING APPLIES:

☐ TYPHOID ☐ RABIES ☐ TETANUS ☐ ENCEPHALITIS
☐ SCARLET FEVER ☐ DIPHTHERIA ☐ SPINAL MENINGITIS

MORE INFO: _____

AMOUNT CLAIMED _____ CURRENCY _____

AMOUNT CLAIM (IN RESPECT OF MEDICAL EXPENSES)		**ARM USE ONLY**	
DESCRIPTION	AMOUNT CLAIMED		EXCHANGE RATE
	TOTAL		

PLEASE ATTACH THE FOLLOWING TO THIS CLAIM FORM:

☐ COPY OF MEDICAL REPORT FROM ATTENDING HOSPITAL/PHYSICIANS
☐ SUMMARY OF EXPENSES
☐ MEDICAL EXPENSES RECEIPTS
☐ ADDITIONAL INFO

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT ANY FALSE INFORMATION CONTAINED HEREIN MAY BE GROUNDS FOR PROSECUTION AND MAY BE PUNISHABLE BY FINE OR IMPRISONMENT, AND WILL NULL AND VOID MY COVERAGE.

PRINT NAME: _____ SIGNATURE: _____ DATE: _____