

Insurance Section

- Church Accident Claim Form



You can do it!



RISK MANAGEMENT SERVICES, INC.

CHURCH ACCIDENT PROGRAM CLAIM FORM

MAIL FORM TO: Arkansas-Louisiana Conference of SDA
 PO Box 31000
 Shreveport, LA 71130



TO BE COMPLETED BY CHURCH ORGANIZATION PART I

Name of Conference: ARKANSAS - LOUISIANA CONFERENCE

Name of Church/Camp & Address of Church/Camp:

1. Covered Person's Last Name First Name M.I. Date of Birth Sex Name of Parent or Guardian

2. Date of Accident/Sickness Time of Accident/Sickness Covered Person's Address (Street, State, Zip Code)

3. Name of Injury/Sickness

4. How and where did Accident/Sickness happen? If sickness claim, please give details.

5. Did Accident/Sickness occur (check yes or no)		Yes	No	Date of Accident/Sickness Reported	
a) Location:	Church Function			Name of leader	Title of Leader
	VBS			Name of Witness	Daytime Phone
	Club Meeting			Name of Witness	Daytime Phone
	Camping			Name of Witness	Daytime Phone
	Other:			Name of Witness	Daytime Phone
b)	While claimant was supervised			Type of Activity	
c)	During sponsored activity			Time Activity Commenced:	a.m. p.m.
d)	During programmed hours			Time Activity Dismissed:	a.m. p.m.
e)	On activity premises				
f)	While traveling to or from an activity in an authorized automobile				
g)	In the course of your employment				

6. I hereby certify that the statements made above are correct to the best of my knowledge and belief and that the above claimant was covered hereunder at the time of the Accident/Sickness.

Signature _____
 Supervisory Official _____ Title _____ Date _____

ATTACH PHYSICIAN'S STATEMENT AND/OR ITEMIZED BILLING TO THIS FORM



Adventurers 2007 - 2008 Arkansas - Louisiana Conference



CONTINUATION OF CHURCH ACCIDENT PROGRAM CLAIM FORM

TO BE COMPLETED BY CLAIMANT, PARENT OR GUARDIAN PART II

Adventurers 2007 - 2008 Arkansas - Louisiana Conference

7. Make check payable to:
Claimant/Parent/Guardian _____ Hospital _____
Insurance Group _____ Doctor(s) _____

8. Name and address of Doctor(s)

9. Name and address of Hospital

10. What other insurance and/or health care assistance do you have covering this loss?
List name(s) of provider involved:

Examples: _____ 1. Medical Insurance (Blue Cross & Blue Shield)
_____ 2. HMO – MD IPA, Kaiser Permanente
_____ 3. SDA Health Care Assistance
_____ 4. Medicare or Medicaid
_____ 5. Other _____

11. _____ I am enclosing a copy of my company’s payment of this claim.
_____ I do not have (nor does my spouse have) any other plan providing medical expense/health care assistance

Name of Employer _____ Phone Number _____
Spouse’s Employer _____ Phone Number _____

The CAP benefits are provided for covered expenses incurred within 1 year after the date of the accident. The first \$500 of covered expenses is paid regardless, of another Plan Providing Medical Expenses Benefits. Addition charges are payable when they are in EXCESS of another Plan Providing Medical Expenses Benefits to the applicable maximum. If you are not covered by another Plan Providing Medical Expense Benefits, the excess provision shall not apply, and benefits are payable to the \$5,000.00 limit.

IMPORTANT: CLAIM FORM MUST BE SIGNED IN ITEM 12

12. I hereby certify that the injury or sickness occurred as stated and that all treatments listed above were due entirely to this claim; that the claim was not a result of a congenital, pre-disposing or pre-existing condition. I hereby authorize any physician or hospital who has treated the above claimant to furnish the insurance company or its representative any information requested. A photocopy of this authorization is to be considered valid.

Signature of Claimant, Parent or Guardian _____ Date of Signature _____

Address of Claimant, Parent or Guardian _____

IMPORTANT CLAIM FILING INSTRUCTIONS
*** All covered accidental bodily injuries and sickness must be responded to the leader/director immediately.
*** It is the responsibility of the covered person to see that this report is mailed to Risk Management Services within ninety (90) days from date of accident.

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