Claim Report Form

AIL OFFICE USE ONLY:
CL#_____
SC:_____
L#:_____

PART 1

Policy # 50635

Serial # R10516 Dates Person Was Insured_____

Name of Policy Holder/Group Baptist Collegiate Ministry
Baptist General Convention of Oklahoma

PART 2

Name of Patient _____

Patient Date of Birth _____ Age _____ Sex M F

Home Address of Patient _____

City _____ State_____ Zip_____

Patient is:
- ☐ Camper/Member
- ☐ Counselor/Instruct.
- ☐ Salaried Staff Eligible Work Comp.
- ☐ Summer Staff
- ☐ Volunteer Leader

INJURY- ILLNESS REPORT

PART 3

Date of Injury/ Illness: Time: Group Activity:

Nature of Injury or Illness: Was this condition already present before this person became insured? ☐ Yes ☐ No

Describe How and Where Injury Occurred (explain fully): *If yes, please explain*

If there was no medical treatment during insured period, was injury or illness reported to staff member? ☐ Yes ☐ No

Office Use:

Verification Signature

PART 4

This form is to be completed by the Camp Director, Chaperone, or Group Leader of the Event - UNRELATED to patient

I hereby certify that this was a supervised group activity sponsored by the organization covered under this policy.

I was the: ☐ Camp Director ☐ Extension Personnel ☐ Group Leader ☐ Other (define) _____

Contact (**Print Name**)_____ Title: _____

Signed:_____

Name of Camp _____ Day Time Phone: _____

For prompt service please attach all itemized bills for services rendered (doctor, hospital and prescriptions).

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 subjects such person to criminal and civil penalties.

ASSIGNMENT FORM – Receipts must be enclosed

ONLY COMPLETE IF MEDICAL BILLS HAVE BEEN PAID BY PATIENT/GUARDIAN

PART 5

I hereby authorize the American Income Life Insurance Company to reimburse eligible medical benefits on the above claim to:

(Payee Name) _____ is to be reimbursed.

Address _____ City _____ State _____ Zip _____

Phone #: _____ Email: _____

Date _____ Signed_____

FOR MEDICAL RELEASE AUTHORIZATION: COMPLETE REVERSE SIDE

Release of Medical Information Authorization

PART 6

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, that has any records of me or my health, to give to the American Income Life Insurance Company or its reinsurers any such information with respect to illness, injury, medical history, consultation, or treatments which include alcohol, drug or chemical dependency treatment. Information received is for the purpose of evaluating this claim and determining our liability under your existing coverage with American Income Life Insurance Company. This authorization shall remain valid for one year. You have the right to receive a copy of this authorization upon request. A photographic copy of this authorization shall be as valid as the original.

_____ _____

Signature of Patient/Guardian/ or Personal Representative Date

How to File a Claim

1. Written notice of claim or Claim Report must be given to the company within thirty days of commencement of any loss covered by this policy.

2. All claim reports must be completed and signed by the camp director, chaperone, or group leader who is UNRELATED TO THE PATIENT. Report the following:

    1. Name of the injured/ill person (patient).
    2. Patient's Date of Birth
    3. Date of the incident (for either an injury or an illness).
    4. How injury/illness was sustained.
    5. Signature for Medical Information Authorization

3. Please provide:

    A. Complete medical diagnosis by the attending physician.
    B. Itemized statements for services rendered by physician or hospital.
    C. Prescription receipts complete with patients name, Rx number, name of prescription, and price.
    D. Proof of payment with an itemized bill if payment has been made.

Payment is made directly to the medical provider unless otherwise indicated on Part 5.

Mail or Fax this Claim Report directly to company. DO NOT rely on medical providers to forward this Claim Report.

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Special Risk Division
P.O. Box 50158
Indianapolis, IN 46250
Ph: 317-849-5545
Fax: 317-849-2793
Web: www.americanincomelife.com

All correspondence will be directed to the policyholder.