Adventist Risk Management, Inc.

VOLUNTEER LABOR

GBG ACCIDENT MEDICAL EXPENSE

Adventist Risk Management, Inc.
12501 Old Columbia Pike - Silver Spring, MD 20904
PHONE : 1-888-951-4ARM (4276) | **FAX :** (301) 453-7060
E-MAIL: claims@adventistrisk.org

HOW TO FILE A CLAIM

1. Complete all items on the attached claim form.

2. Attach the following documents:
   - Letter from church pastor, head elder or conference employee verifying accident occurred while volunteer was participating in a scheduled, sponsored and supervised volunteer activity, or traveling to or from such activity.
   - Copies of fully itemized medical bills. Itemized bills must show the patient's name, date of service, the type of service rendered, the diagnosis or nature of condition being treated and the provider's name and address.
   - Copies of the Explanation of Benefits from your primary insurance carrier

3. Send the completed and signed claim form and all required documents to:

Adventist Risk Management, Inc.
12501 Old Columbia Pike Silver Spring, MD 20904
Email:claims@adventistrisk.org
Phone: 1 (888) 951-4ARM (4276)
Fax: (301) 453-7060

4. Retain a copy for your records.

This insurance plan is excess insurance and is designed to provide maximum benefits at minimum cost and is secondary to all other insurance you may have. Please submit all expenses to your primary insurance first. Once that claim has been processed, please include their Explanation of Benefits when submitting your claim for benefits under this policy. Attention Medicare and Medicaid Enrollees: This insurance is primary to your Medicare or Medicaid coverage. If you wish payment to be made to you, you must provide proof of payment from the provider.

YOU WILL BE CONTACTED BY A CLAIM ADJUSTER IF ADDITIONAL INFORMATION OR DOCUMENTATION IS REQUIRED.

Accident Medical Expense

Insured's Statement

(Please print – Attach separate sheet if additional space required)

INSURED INFORMATION

Insured's Name_____ **Social Security #**_____

Insured's Address_____ **Phone No. (H)**_____

_____ **Phone No. (W)**_____

Email address: _____ **Phone No. (C)** _____

Policy Number (Required)_____ **Insured's Date of Birth** _____/_____/_____

Are you eligible for or enrolled in Medicare? _____ **Are you enrolled in Medicaid?** _____

CLAIM INFORMATION

Date of accident _____/_____/_____ **Time and place accident occurred**_____

Please describe in detail the circumstances of accident (attach separate sheet if needed): _____

_____

Was the accident related to the Insured's occupation? _____ **If so, how?** _____

Please describe the nature of Insured's injuries:_____

Did police or other authorities investigate the accident? ____ **If yes, please provide name, address and telephone number of all investigating officers and agencies:** _____

Please list the names and addresses of all treating/consulting physicians or other healthcare providers:

Name	Street Address	City	State	Zip	Phone

_____

_____

If hospitalized, please provide name and address of hospital(s) where treatment was received:

_____

Do you have any other insurance that may provide coverage for this accident or loss? _____ **If yes, please identify name, address, and policy number of all other insurance:** _____

_____

AUTHORIZATION AND ASSIGNMENT OF BENEFITS

I hereby authorize any hospital, physician, employer, or other person who has attended or examined the Insured to disclose when requested to do so, any information to NAHGA Claim Services with respect to any injury, policy coverage, medical history, consultations, prescriptions or treatment as well as providing copies of all hospital and medical records and itemized bills. I know I have a right to receive a copy of this authorization upon request and agree that a photographic or facsimile copy of this authorization is as valid as the original. I swear that the above information is true and correct to the best of my knowledge and understand that any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete or misleading information or who willfully conceals material information may be subject to prosecution for insurance fraud.

Signed (Insured or authorized person) _____ **Date** ____/____/____

I authorize payment of medical benefits directly to the provider(s) for services rendered in connection with this claim.

Signed (Insured or authorized person)_____ **Date** ____/_____/___

AUTHORIZATION TO RELEASE INFORMATION

I authorize Chubb & Son, a division of Federal Insurance Company ("Chubb") and NAHGA to release certain information regarding my claim, including my name, address and medical information to Adventist Risk Management ("ARM"), Global Benefits Group ("GBG") and its agents to facilitate the administration of the claim and of the policy. I understand that any information I provide to ARM, GBG or its agents is governed by the privacy policy and procedures of the respective organizations and that these organization are not Chubb service providers and Chubb is not responsible for their actions. This authorization shall be valid for 24 months and may be revoked at any time subject to the rights of the individual who acted in reliance on the authorization prior to the notice of the revocation. To revoke this authorization, contact your client representative.

Signed (Insured or authorized person) _____ **Date** _____/_____/_____

IMPORTANT NOTICE

Notice to Alaska Claimants: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Notice to Arizona Claimants: For your protection, Arizona law requires the following statement to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Notice to Arkansas Claimants: 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.

Notice to California Claimants: For your protection, California law requires the following to appear on 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.

Notice to Colorado Claimants: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties many include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Notice to Delaware Claimants: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement or claim containing any false, incomplete, or misleading information is guilty of a felony.

Notice to District of Columbia Claimants: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Notice to Florida Claimants: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information, is guilty of a felony of the third degree.

Notice to Idaho Claimants: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete, or misleading information, is guilty of a felony.

Notice to Indiana Claimants: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Notice to Kentucky Claimants: 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 thereto commits a fraudulent insurance act, which is a crime.

Notice to Maine Claimants: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

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

IMPORTANT NOTICE

Notice to Minnesota Claimants: A person who submits an application or files a claim with intent to defraud or helps commits a fraud against an insurer is guilty of a crime.

Notice to New Hampshire Claimants: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

Notice to New Jersey Claimants: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Notice to New Mexico Claimants: 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 civil fines and criminal penalties.

Notice to New York Claimants: 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.

Notice to Ohio Claimants: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Notice to Oklahoma Claimants: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Notice to Oregon Claimants: Any person who, knowingly and with intent to defraud an insurance company or other person, submits an application or files a claim for insurance that contains any materially false information relating to an insurance company's acceptance of risk, or conceals for the purpose of misleading, information concerning any fact material to an insurance company's acceptance of risk, may be guilty of a fraudulent act, which is a crime.

Notice to Pennsylvania Claimants: 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.

Notice to Virginia Claimants: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Notice to Claimants in all other states: Any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete or misleading information may be subject to prosecution for insurance fraud.