PERSONAL ACCIDENT (Accident & Sickness)
Policy No. 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

Programme: **INTERNATIONAL CAMPERS PROGRAMME** **Option chosen:** _____

INSTRUCTIONS:

1. SECTION A must be 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 itemised 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 NO. (IF AVAILABLE)	DATE OF BIRTH	NAME OF SUPERVISOR

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

DESCRIPTION OF LOSS

DATE OF LOSS DA MO 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 PROGRAMME HOURS?	○ YES	○ NO
D.	WHILE TRAVELLING TO OR FROM REGULARLY SCHEDULED ACTIVITY IN A SUPERVISED GROUP?	○ YES	○ NO

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

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

SIGNATURE OF POLICYHOLDER REPRESENTATIVE	DATE DA MO YR

SECTION B – MUST BE COMPLETED

LIST NAME, ADDRESS, AND TELEPHONE NO. OF OTHER INSURANCE COMPANIES UNDER WHICH CLAIMANT IS INSURED:	POLICY NO./ACCOUNT NO.

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 NO.

CITY	COUNTY	POSTCODE	COUNTRY

EMPLOYER NAME (IF CLAIMANT IS A MINOR, GUARDIAN'S EMPLOYER NAME)	EMPLOYER'S DAYTIME TELEPHONE NO.

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

CITY	COUNTY	POSTCODE	COUNTRY

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

AUTHORISATION AND ASSIGNMENT OF BENEFITS

I, the undersigned authorise any hospital or other medical care institution, doctor or other medical professional, pharmacy, insurance support organisation, government agency, group policyholder, insurance company, association, employer or benefit plan administrator to provide 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 drug and alcohol use, to determine eligibility for benefit payments under the Policy Number identified above. I authorise 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 authorisation is valid for the term of coverage of the Policy identified above and that a copy of this authorisation shall be considered to be as valid as the original. I understand that I or my authorised representative may request a copy of this authorisation.

I AUTHORISE PAYMENT OF MEDICAL BENEFITS TO THE DOCTOR OR SUPPLIER FOR SERVICES PERFORMED. ☐ **YES** ☐ **NO**

CLAIMANT OR AUTHORISED PERSON'S SIGNATURE	DATE DA MO YR

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COVERED LOSSES (Please tick 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: _____

TELEPHONE NO: _____ TELEPHONE NO: _____

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

IF YES, PLEASE PROVIDE THE FOLLOWING

1. DATE OF CONSULTATION — DA _____ MO _____ YR _____
2. NAME AND ADDRESS OF DOCTOR CONSULTED — FULL NAME: _____ ADDRESS: _____

NAME AND ADDRESS OF YOUR FAMILY 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 LEUKAEMIA
- ☐ TULARAEMIA

☐ OTHER SICKNESS

MORE INFO:

IF SO, PLEASE TICK 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/DOCTORS
☐ 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: _____