



How to File a Claim

1. Written notice of claim, or Claim Report Form, must be provided to the company within twenty days from the date of incident covered by this policy, but no later than ninety days from the date of incident.
 - Complete the entire claim report (Parts 1-6); the claim report must be signed by a camp director, chaperone, or group leader who is UNRELATED TO THE PATIENT.
 - Valid claim reports must contain the following information:
 - a. Policy number and serial number
 - b. Full legal name of the injured/ill person (patient)
 - c. Patient's date of birth & age
 - d. Current mailing address
 - e. Date of the incident (injury or illness)
 - f. How injury was sustained or the nature of the illness
 - g. Verification signature by Camp Director, Extension Personnel, Group Leader, or Chaperone
 - h. Signature for Release of Medical Information Authorization

2. Eligible medical statements must be provided within one year from the date of treatment.
For claim review provide:
 - a. Itemized statements for services rendered by physician or hospital, including diagnosis and procedure codes.
 - b. Prescription receipts complete with patient's name, Rx number, name of prescription, and price.
 - c. Proof of payment along with an itemized bill if payment has been made.
Proof of payment would be a paid receipt from provider, credit card receipt, or cancelled check.
 - d. Explanation of Benefits for claims paid by personal insurance.

NOTE:

Payment is made directly to the medical provider unless otherwise indicated on the Assignment Form (Part 5).

Mail, Fax, or Email the completed Claim Report Form **directly to the company.**

DO NOT rely on medical providers to forward.

American Income Life Insurance Company
Special Risk Division
P.O. Box 50158
Indianapolis, IN 46250
Ph: 800-849-4820
Fax: 317-849-2793

Claim Department Email: claims@americanincomelife.com

Web: www.americanincomelife.com



PART 1

Policy # Serial # Dates Person Was Insured

Name of Policy Holder/Group

PART 2

Name of Patient

Patient Date of Birth Age Sex M F

Patient Home Address

City State Zip

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

Injury - Illness Report

Date of Injury/Illness: Time: Group Activity:

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

PART 3

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

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

PART 4

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)

Name of Camp

Contact (Print Name) Title:

Signed:

Day Time Phone: Email

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.

Send completed claim forms to: AIL-SRD, P.O. Box 50158, Indianapolis, IN 46250 Email: claims@americanincomelife.com Fax: 317-849-2793



Name of Patient: _____ Patient Date of Birth: _____

Patient Home Address _____

City _____ State _____ Zip _____

Assignment Form – Receipts must be enclosed

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

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

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(Payee Name) _____ is to be reimbursed.

Address _____ City _____ State _____ Zip _____

Phone #: _____ Email: _____

Date _____ Signed _____

Release of Medical Information Authorization

P
A
R
T
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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

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Fax: 317-849-2793