# CLAIM REPORT

**To be completed by the Camp Director, Chaperone, or Group Leader of the Event.**

**American Income Life Insurance Co.**
Special Risk Division
P.O. Box 50158
Indianapolis, IN 46250
800-849-4820

**PART 1**

**Policy # _____**

Policy Holder: _____

Serial # _____

Dates Person Was Insured _____ to _____

Name of Camp/Club/Group_____

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

**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

**PART 3**

## INJURY REPORT

Date of Injury: Time:

Group Activity:

Describe How and Where Injury Occurred (**explain fully**):

***Office Use:***

## ILLNESS REPORT

Date Insured First Noticed Symptoms:

Nature of Illness:

Was this condition already present before this person became insured? ☐ Yes ☐ No

If YES, please explain:

***Office Use:***

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

**PART 4**

## Verification Signature - 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 ☐ Chaperone ☐ Group Leader ☐ Other (define) _____

Contact (Print Name)_____ Title: _____

Signed:_____

Name of Camp/Org. _____ Day Time Phone: _____

**PART 5**

## ASSIGNMENT FORM

**I hereby authorize the American Income Life Insurance Company to pay benefits on the above claim to:**

☐ Medical Provider(s) [Check is sent directly to the facility providing the medical services.]

☐ (Payee Name) _____ is to be reimbursed. **Receipts must be enclosed**

Address _____ City _____ State _____ Zip _____

Date _____ Signed_____