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, INDIANA 46250
(317) 849-5545 • FAX (317) 849-2793

Medicare MUST be filed as primary carrier.

PART 1

POLICY # ______________

SERIAL NUMBER ______________________

DATES PERSON WAS INSURED ____________________________

Name of Session/Club/Group ____________________________ Policyholder ____________________________

For prompt service please attach Physician/Emergency Room Report and all itemized bills for services rendered (doctor, hospital and prescriptions).

PART 2

Name of Patient ____________________________ Age ________ Sex ________

Address of Patient ____________________________

City ____________________________ State ________ Zip Code ________

Patient is:
- ☐ Camper / Member
- ☐ Counselor / Instructor
- ☐ Salaried Staff Eligible for Workman's Comp.
- ☐ Summer Staff
- ☐ Volunteer Leader

PART 3

INJURY REPORT		ILLNESS REPORT
DATE OF INJURY	TIME	DATE INSURED FIRST NOTICED SYMPTOMS
GROUP ACTIVITY		NATURE OF ILLNESS
HOW AND WHERE INJURY OCCURRED (EXPLAIN FULLY)		
		WAS THIS CONDITION ALREADY PRESENT BEFORE THIS PERSON BECAME INSURED? ☐ Yes ☐ No
DESCRIBE INJURIES		IF YES, PLEASE EXPLAIN

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 (please define ____________________________)

SIGNED ____________________________

Day Time Phone No.

____
Name of Camp / Organization

PART 5

ASSIGNMENT FORM

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

☐ Medical Provider

☐ ____________________________ ☐ Receipt and statement enclosed.
Name of Payee

____________________________ ☐ Statement marked paid enclosed.
Address of Payee

Dated ______________ Signed ____________________________

10M-99