AMERICAN INCOME LIFE
insurance company

SPECIAL RISK
DIVISION

P.O. Box 50158
Indianapolis, IN 46250
800-849-4820
Fax: 317-849-2793

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

CLAIM REPORT

PART 1

Policy # _____ Policy Holder: _____

Serial # _____ Name of Camp/Club/Group _____

Dates Person Was Insured _____

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	ILLNESS REPORT
Date of Injury: Time:	Date Insured First Noticed Symptoms:
Group Activity:	Nature of Illness:
Describe How and Where Injury Occurred (**explain fully**):	Was this condition already present before this person became insured? ☐ Yes ☐ No
	If YES, please explain:
Office Use:	***Office Use:***

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

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

Contact (**Print Name**) _____ Title: _____

Signed: _____

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

ASSIGNMENT FORM

PART 5

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 _____

How to File a Claim

1. Written notice of claim or Claim Report must be given to the company within twenty days of commencement of any loss covered by this policy *or as soon as is reasonably possible.*

2. All claim reports must be completed and signed by the camp director, chaperone, or group leader who is UNRELATED TO THE PATIENT. Report the following:

   A. Name of the injured/ill person (patient).
   B. Patient's Date of Birth
   C. Date of the disability (for either an injury or an illness).
   D. How disability was sustained.

3. Please provide:

   A. Complete medical diagnosis by the attending physician.
   B. Itemized statements for services rendered by physician or hospital.
   C. Prescription receipts complete with Rx number, name of prescription, and price.
   D. Proof of payment with an itemized bill if payment has been made.

Payment is made directly to the medical provider unless otherwise indicated on Part 5.

Mail or Fax this Claim Report directly to company. DO NOT rely on medical providers to forward this Claim Report.

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Special Risk Division
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Fax: 317-849-2793
Web: www.americanicomelife.com

All correspondence will be directed to the policyholder.

Pennsylvania: 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.