NORTH AMERICAN DIVISION MEDICAL PAYMENTS (ed. 09/2013)
CLAIM FORM

12501 Old Columbia Pike
Silver Spring, MD 20904
OFFICE: (301) 680-6870 FAX: (301) 680-6878 EMAIL: claims@adventistrisk.org

TO BE COMPLETED BY CHURCH ORGANIZATION			
CONFERENCE			
CHURCH NAME CHURCH ADDRESS			
CHURCH CONTACT PERSON		TELEPHONE	
	EMAIL ADDRESS		

ABOUT THE INJURED PERSON

PLEASE COMPLETE ALL FIELDS BELOW. THOSE MARKED WITH AN (*) ARE REQUIRED.

FIRST NAME*		LAST NAME*	
DATE OF BIRTH*		GENDER*	
SOCIAL SECURITY NUMBER*			
ADDRESS			
	TELEPHONE	EMAIL ADDRESS	
NAME OF PARENT/GUARDIAN			
DATE OF ACCIDENT*		TIME OF ACCIDENT	
DESCRIBE THE INJURY*			
HOW DID ACCIDENT HAPPEN?*			
LOCATION OF ACCIDENT		DATE ACCIDENT REPORTED*	
TYPE OF ACTIVITY			
TIME ACTIVITY	COMMENCED	DISMISSED	

DID ACCIDENT OCCUR DURING: (CIRCLE YES OR NO)			ACTIVITY LEADER		TITLE	
CHURCH FUNCTION	Y	N	NAME AND ADDRESS OF WITNESS			TELEPHONE
VACATION BIBLE SCHOOL	Y	N				
PATHFINDER	Y	N				
CAMP	Y	N				
OTHER	Y	N	NAME AND ADDRESS OF WITNESS			TELEPHONE
WHILE SUPERVISED	Y	N				
DURING SPONSORED ACTIVITY	Y	N				
DURING PROGRAMMED HOURS	Y	N				
ON ACTIVITY PREMISES	Y	N	NAME AND ADDRESS OF WITNESS			TELEPHONE
WHILE TRAVELING TO OR FROM AN ACTIVITY IN AN AUTHORIZED AUTOMOBILE	Y	N				
IN THE COURSE OF YOUR EMPLOYMENT	Y	N				
DOES THE INJURED PERSON HAVE OTHER INSURANCE?	Y	N	NAME AND ADDRESS OF OTHER INSURANCE:			

I hereby certify that the statements made above are correct to the best of my knowledge and believe that the above claimant was covered hereunder at the time of the accident/sickness.

Signature of Supervisory Official_____Date_____

ATTACH PHYSICIAN'S STATEMENT AND/OR ITEMIZED BILLING TO THIS FORM