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 # 4913

Serial # _____

Policy Holder: _____

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	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***

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_____