Adventist Risk Management, Inc.

12501 Old Columbia Pike, Silver Spring MD 20904
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MEDICAL PAYMENTS CLAIM FORM

TO BE COMPLETED BY CHURCH ORGANIZATION

CONFERENCE

CHURCH & ADDRESS:

Contact Person:	Phone:	Email:

(1) Person's Last Name First Name M. I.	Date of Birth	Sex	SS#

(2) Person's Address (Street, City, State, Zip Code)	Date of Accident: ____________________ Time of Accident: ____________________
Telephone #: ____________________	Name of Parent or Guardian

(3) Nature of injury

(4) How did accident happen?

LOCATION OF ACCIDENT ____________________ DATE ACCIDENT REPORTED ____________

(5) Did accident occur during: (check yes or no)	Y	N
Church Function		
VBS		
Pathfinder		
Camp		
Other		
While supervised		
During sponsored activity		
During programmed hours		
On activity premises		
While traveling to or from an activity in an Authorized automobile		
In the course of your employment		
Does injured person have other insurance?		

Type of Activity	
Name of Leader	Title of Leader
Time Activity Commenced a.m.	Time Activity Dismissed p.m.
Name and Address of Witness	Daytime Phone
Name and Address of Witness	Daytime Phone
Name and Address of Witness	Daytime Phone

Name & Address of other Insurance Co.

(6) I thereby certify that the statements made above are correct to the best of my knowledge and belief that the abov claimant was covered hereunder at the time of the accident' sickness.

Signature
Supervisory Official____________________ **Title** ____________________

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

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