Georgia-Cumberland Conference

PROOF OF LOSS – Miscellaneous Accident Assistance

NAME OF GROUP: Georgia-Cumberland Conference of Seventh-day Adventists

POLICY NUMBER: **2012**

MAIL TO:

Georgia-Cumberland Conference
Miscellaneous Accident Assistance
P.O. Box 12000
Calhoun, GA 30703-7001 Ph.: 706-629-7951

INSTRUCTIONS:

1) You must have **SECTION A** fully completed by a designated church official of the Georgia-Cumberland Conference.
2) **SECTION B** is to be completed, signed and dated by the claimant or parent/guardian of claimant, if claimant is a minor.
3) If claimant is treated in the hospital, please attach an itemized hospital bill.
4) If claimant is treated by a doctor, have the doctor complete the Physician's Statement or attach an itemized bill.
5) Attach itemized bills for all medical expenses being claimed including the claimant's name, condition being treated (diagnosis), description of services, date of service(s) and the charge made for each service.
6) Please mail completed form and bills to above address.

The furnishing of this form, or its acceptance by the Georgia-Cumberland Conference, must not be construed as an admission of any liability on Georgia-Cumberland Conference, nor a waiver of any of the conditions of this assistance. Any person who knowingly and/or with intent to injure, defraud, or any person who files a statement of claim containing false, incomplete or misleading information, may be guilty of fraud and subject to criminal and substantial civil penalties.

SECTION A

INDIVIDUAL'S FULL NAME	SUPERVISOR/PASTOR/LEADER	
NATURE OF INJURY (DESCRIBE FULLY , WHICH PART OF BODY WAS INJURED)		DATE AND TIME OF ACCIDENT

WHERE DID INJURY occur?

_____

HOW DID INJURY OCCUR?

DID ACCIDENT OCCUR:

A. WHILE CLAIMANT WAS SUPERVISED	☐ YES	☐ NO
B DURING SPONSORED ACTIVITY	☐ YES	☐ NO
C DURING PROGRAMMED HOURS	☐ YES	☐ NO

SUPERVISOR/PASTOR/LEADER'S NAME	TELEPHONE NUMBER ( )
SIGNATURE OF SUPERVISOR/PASTOR/LEADER	DATE

SECTION B

NAME OF CLAIMANT	TELEPHONE NO. ( )
ADDRESS OF CLAIMANT (PARENT OR GUARDIAN IF A MINOR)	

OTHER HEALTH INSURANCE COVERAGE ☐ YES ☐ NO (IF YES, ENTER NAME AND ADDRESS OF INSURANCE COMPANY AND POLICY NUMBER)

AUTHORIZATION

I, the undersigned authorize any hospital or other medical-care institution, physician or other medical professional, pharmacy, insurance support organization, governmental agency, group policyholder, insurance company, association, employer or benefit plan administrator to furnish to the Insurance Company named above or its representative, any and all information with respect to any injury or sickness suffered by, the medical history of, or any consultation, prescription or treatment provided to, the person whose death, injury, sickness or loss is the basis of claim and copies of all of that person's hospital or medical records, including information relating to mental illness and use of drugs and alcohol, to determine eligibility for benefit payments under the Policy Number identified above. I authorize the group policyholder, employer or benefit plan administrator to provide the Insurance Company named above with financial and employment related information. I understand that this authorization is valid for the term of coverage of the Policy identified above and that a copy of this authorization shall be considered as valid as the original. I understand that I or my authorized representative may request a copy of this authorization. I hereby certify that the above information is true and correct to the best of my knowledge and belief

_____

SIGNATURE (CLAIMANT, or parent if claimant is a minor) **DATE**

SECTION B continued **PROOF OF LOSS NOTICE**

CLAIMANT INFORMATION

PATIENT'S DATE OF BIRTH _____/_____/_____	SEX Male Female	SOCIAL SECURITY NUMBER
STATUS Single Married Other Employed Full Time Student part-time Student	10. IS PATIENT'S CONDITION RELATED TO: A. PATIENT'S EMPLOYMENT? YES NO B. AN AUTO ACCIDENT? YES NO C. OTHER ACCIDENT? YES NO	IF PATIENT HAS HAD SAME OR SIMILAR INJURY GIVE FIRST DATE: MM DD YR / /
EMPLOYER'S NAME OR SCHOOL NAME	ADDITIONAL INFORMATION YOU WANT TO PROVIDE	
NAME OF TREATING DOCTOR/HOSPITAL/CLINIC	PHONE NO DOCTOR/HOSPITAL/CLINIC	Dates Patient Unable To Work in Current Occupation MM / DD / YY MM / DD / YY FROM / / TO / /
DATE OF SERVICE		Hospitalization Dates Related to Current Services MM / DD / YY MM / DD / YY FROM / / TO / /
DIAGNOSIS OR NATURE OF INJURY 1 _____ _____ 3 _____ _____ 2 _____ _____ 4 _____ _____		TOTAL CHARGES