



Adventist Risk Management, Inc.

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**MEDICAL
 PAYMENTS
 CLAIM FORM**

TO BE COMPLETED BY CHURCH ORGANIZATION

CONFERENCE					
CHURCH & ADDRESS:					
(1) Person's Last Name	First Name	M. I.	Date of Birth	Sex	Name of Parent or Guardian
(2) Person's Address (Street, City, State, Zip Code)			Date of Accident: _____		
Telephone #: _____			Time of Accident: _____		
(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	Type of Activity		
Church Function			Name of Leader		Title of Leader
VBS			Time Activity Commenced a.m.		Time Activity Dismissed p.m
Pathfinder			Name and Address of Witness _____ Daytime Phone _____		
Camp					
Other			Name and Address of Witness _____ Daytime Phone _____		
While supervised					
During sponsored activity			Name and Address of Witness _____ Daytime Phone _____		
During programmed hours					
On activity premises			Name and Address of Witness _____ Daytime Phone _____		
While traveling to or from an activity in an Authorized automobile					
In the course of your employment					

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

Signature
Supervisory Official _____ **Title** _____

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