



NORTH AMERICAN DIVISION MEDICAL PAYMENTS STATEMENT OF LOSS

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TO BE COMPLETED BY CHURCH ORGANIZATION

CONFERENCE: _____

CHURCH NAME: _____

CHURCH ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

CHURCH CONTACT PERSON: _____

TELEPHONE | BUSINESS: _____ RESIDENTIAL: _____ EMAIL ADDRESS: _____

▶ ABOUT THE INJURED PERSON:

FIRST NAME: _____ M.I. _____ LAST NAME: _____ DATE OF BIRTH: _____ (MM/DD/YYYY) SOCIAL SECURITY #: _____ MALE _____ FEMALE _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

TELEPHONE | BUSINESS: _____ RESIDENTIAL: _____ EMAIL ADDRESS: _____

NAME OF PARENT / GUARDIAN*: _____ DATE OF ACCIDENT: _____ (MM/DD/YYYY) TIME OF ACCIDENT: _____ AM _____ PM _____

DESCRIBE THE INJURY: _____

HOW DID ACCIDENT HAPPEN?:

LOCATION OF ACCIDENT - ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

DATE ACCIDENT REPORTED: _____ (MM/DD/YYYY) TYPE OF ACTIVITY: _____ TIME OF ACTIVITY - COMMENCED: _____ DISMISSED _____

DOES THE INJURED PERSON HAVE OTHER INSURANCE? YES NO

OTHER INSURANCE NAME: _____

OTHER INSURANCE - ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

▶ DID THE ACCIDENT OCCUR DURING:

ACTIVITY - LEADER: _____			DURING SPOSED ACTIVITY: _____	YES	NO
TITLE: _____			DURING PROGRAMMED HOURS: _____	YES	NO
CHURCH FUNTION: _____	YES	NO	CAMP: _____	YES	NO
VACATION BIBLE SCHOOL: _____	YES	NO	OTHER: _____	YES	NO
PATHFINDER: _____	NO		WHILE SUPERVISED: _____	YES	NO
			ON ACTIVITY PREMISES: _____	YES	NO
			WHILE TRAVELING TO OR FROM AN ACTIVITY IN AN AUTHORIZED AUTOMOBILE: _____	YES	NO
			IN THE COURSE OF YOUR EMPLOYMENT: _____	YES	NO

▶ WITNESSES:

FIRST NAME: _____ TELEPHONE | BUSINESS: _____ RESIDENTIAL: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

FIRST NAME: _____ TELEPHONE | BUSINESS: _____ RESIDENTIAL: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

FIRST NAME: _____ TELEPHONE | BUSINESS: _____ RESIDENTIAL: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

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 (MM/DD/YYYY): _____

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