4-H Accident Insurance Coverage

American Income Life Insurance

CLAIM INSTRUCTIONS

1. Claim Report Form must be submitted within twenty days of the incident.

2. Complete Parts 1-6 of the claim form

3. Submit your claim form to the Extension Office for signature. The Claim Form must be signed by Extension staff.

4. Valid claim reports must include the following:
   a. Policy number (provided on claim form)
   b. Full legal name of the injured party
   c. Patient’s date of birth
   d. Current mailing address
   e. Date of the incident
   f. How the injury occurred
   g. Verification signature (see #3 above)
   h. Signature for the Release of Medical Information Authorization (back of Claim Report Form)

5. Eligible medical statements must be provided within one year from the date of treatment.
   a. Itemized statements for services rendered by physician or hospital, including diagnosis and procedure codes.
   b. Prescription receipts complete with patient’s name, RX number, name of prescription, and price.
   c. Proof of payment along with an itemized bill if payment has been made.
   d. Explanation of Benefits for claims paid by personal insurance.

NOTE: Payment is made directly to the medical provider unless otherwise indicated on the Assignment Form (Part 5, back of form.)

Mail, Fax, or Email the completed Claim Report Form directly to the company.

American Income Life Insurance Company
Special Risk Division
PO Box 50158
Indianapolis, IN 46250
PH: 800-849-4820
FAX: 317-849-2793
Claim Email: claims@americanincomelife.com
Policy # A WA50166       Serial # __________________       Dates Person Was Insured 10/01/2017

Name of Policy Holder/Group Washington State 4-H

Name of Patient __________________________________________

Injury - Illness Report

Date of Injury/Illness:       Time: Group Activity:

Nature of Injury or Illness:       Was this condition already present before this person became insured? □ Yes □ No

Describe How and Where Injury Occurred (explain fully): If yes, please explain

If there was no medical treatment during insured period, was injury or illness reported to staff member? □ Yes □ No

Verification Signature

This form is to be completed by the Camp Director, Chaperone, or Group Leader of the Event - 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 □ Extension Personnel □ Group Leader □ Other (define) _____________________________

Name of Camp __________________________________________

Contact (Print Name) _____________________________ Title: _____________________________

Signed: _____________________________________________

Day Time Phone: _____________________________ Email _____________________________

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.
Assignment Form – Receipts must be enclosed
ONLY COMPLETE IF MEDICAL BILLS HAVE BEEN PAID BY PATIENT/GUARDIAN

I hereby authorize the American Income Life Insurance Company to reimburse eligible medical benefits on the above claim to:

(Payee Name) ___________________________________________________________ is to be reimbursed.

Address _____________________________________________ City ______________________ State _____ Zip ____________

Phone #: __________________________ Email: __________________________

Date __________________________ Signed____________________________

Release of Medical Information Authorization

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, that has any records of me or my health, to give to the American Income Life Insurance Company or its reinsurers any such information with respect to illness, injury, medical history, consultation, or treatments which include alcohol, drug or chemical dependency treatment. Information received is for the purpose of evaluating this claim and determining our liability under your existing coverage with American Income Life Insurance Company. This authorization shall remain valid for one year. You have the right to receive a copy of this authorization upon request. A photographic copy of this authorization shall be as valid as the original.

_______________________________________________________  ____________________________________
Signature of Patient/Guardian/ or Personal Representative  Date