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

AMERICAN INCOME LIFE insurance company

SPECIAL RISK DIVISION

Claim Report Form

PART 1

Policy # A WA50166 **Serial #** _____ Dates Person Was Insured 10/01/2017

Name of Policy Holder/Group Washington State 4-H

PART 2

Name of Patient _____

Patient Date of Birth _____ Age _____ Sex M F

Patient Home Address _____

City _____ State_____ Zip_____

Patient is:
- ☐ Camper/Member
- ☐ Counselor/Instruct.
- ☐ Salaried Staff
  - Eligible Work Comp.
- ☐ Summer Staff
- ☐ Volunteer Leader

Injury - Illness Report

PART 3

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**

Office Use:

Verification Signature

This form is to be completed by the Camp Director, Chaperone, or Group Leader of the Event - UNRELATED to patient

PART 4

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.

Contact the Claims Department with questions.
Phone: (800) 849-4820 Email: claims@americanincomelife.com

Send completed claim forms to:
AIL-SRD, P.O. Box 50158, Indianapolis, IN 46250
Email: claims@americanincomelife.com
Fax: 317-849-2793

AMERICAN INCOME LIFE insurance company | SPECIAL RISK DIVISION

Claim Report Form

Name of Patient: _____ Patient Date of Birth:_____

Patient Home Address _____

City _____ State_____ Zip_____

Assignment Form – Receipts must be enclosed

ONLY COMPLETE IF MEDICAL BILLS HAVE BEEN PAID BY PATIENT/GUARDIAN

PART 5

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

PART 6

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

Contact the Claims Department with questions.
Phone: (800) 849-4820 Email: claims@americanincomelife.com

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Email: claims@americanincomelife.com
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