ACCIDENT AND SICKNESS PROOF OF LOSS FORM FOR COMMUNITY OF CHRIST ACTIVITIES

Community of Christ
Risk Management Services
1001 W. Walnut
Independence, MO 64050-3562 USA

NAME AND LOCATION OF INSURED EVENT

SPONSORING (REPORTING) GROUP (I.E. STAKE, CAMP)

NAME OF INSURED INDIVIDUAL

ADDRESS OF INSURED INDIVIDUAL

TELEPHONE OF INSURED INDIVIDUAL

IF AN ACCIDENT	DATE AND TIME OF ACCIDENT AM PM	PLACE OF ACCIDENT
	NATURE OF INJURY	
	WHAT HAPPENED?	
	DESCRIBE GROUP ACTIVITY ENGAGED IN AT TIME OF ACCIDENT	
	NAME OF ACTIVITY DIRECTOR	
	DATE AND NATURE OF THE ILLNESS (*if sickness)*	

CERTIFICATION OF GROUP OFFICIAL:

I certify that the above individual was participating in a church-sponsored activity and at this activity was injured or became ill. I believe the above information on this report is correct.

PLEASE NOTE: Coverage is provided on an “excess” basis. If you have other insurance, billings must be submitted to your insurance company first. After they have made their payment and you still have unpaid bills, please complete this claim form and forward it along with the Explanation of Benefits statement you will receive from your insurance company with copies of the itemized bills to the address shown in the top left corner of this form.

DATE OF REPORT	SIGNATURE OF DIRECTOR	PHONE #

ACCIDENT AND SICKNESS PROOF OF LOSS FORM
STATEMENT OF PARENT OR GUARDIAN

I hereby authorize any hospital, physician, or other person who has attended or examined the insured to furnish to the insurance company, or its representative, any and all information with respect to any illness; medical history, consultation, prescriptions, or treatment, and copies of all hospital or medical records, a photostat copy of this authorization shall be considered as effective and valid as the original.

SIGNATURE OF PARENT OR GUARDIAN	
ADDRESS OF PARENT OR GUARDIAN	DATE

STATEMENT

I have had an accident/illness at a Community of Christ sponsored activity ☐

My child has had an accident/illness at a Community of Christ sponsored activity ☐

Currently I possess: (please check the appropriate statement)

No personal medical insurance that will pay for the medical bills ☐

Medical insurance that pays for only part of the medical bills ☐

PLEASE SIGN BELOW

Participant or Parent(s) or Legal Guardian(s) and Social Security Number(s)

Participant or Parent(s) or Legal Guardian(s) and Social Security Number(s)

Date statement signed