J. Pekala & Associates

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www.churchinsurers.com

Student Medical Claim Report

Please furnish the following information for prompt handling of your claim. You may call this information in our office or you may fax or mail this form to us.

Policyholder Information

Insured's Name (as it appears on policy) ____________________________________

DBA:____

Insured's Address 1 (Street)____

City _________________ State___________________ Zip Code________________

Policy No.____________ Policy Effective Date: _____________

Date reported: ____

Contact (Name): _______________________________ Title ____________________

Phone (Home) __________________________ (Work) _______________________

Phone (Church) _________________________ Fax ___________________________

E-Mail ____

Date of Accident _____________ Time of Accident ______________am___ pm____

Accident Information

Location of Accident (Street) ____

City ___________________ State _________________ Zip Code ________________

Description of Accident- Describe fully-Include rough sketch if possible. (Use additional paper if necessary)

____
____
____
____

Injured Person Information

Name of Injured Person: ________________________________

Age _____ Sex _____ DOB:___________ Social Security #_________________

Grade:_____

Parent/Guardian of minor child __________________________

Address (Street) ____

City _________________ State __________________ Zip Code __________________

Phone (Home) __________________________ (Work) _______________________

Was the accident school related? ____________

Did the accident occur: (Please Circle)

a) while the claimant was supervised? Y or N
b) during sponsored activity? Y or N
c) during programmed hours? Y or N
d) on activity premises? Y or N
e) while traveling directly and uninterruptedly to or from home premises and school for regular school sessions or school sponsored and supervised activities? Y or N

Are you insured under any medical accident policy ? Y or N

If yes, please provide policy number and
Company:____
____

Injuries claimed: ____

Physicians Name: ____

Address (Street) ____

City ________________ State_______________ Zip Code_____________________

Name of Facility where injured was taken ___________________________________

Address (Street) ____

City _______________ State ________________ Zip Code ___________________

Was injured transported by Ambulance? ___ No ___ Yes

<u>Witnesses</u> (Use **Additional Paper if Necessary**)

It is critical to give full name and address of every person who knows anything about the accident.

Name _____________________

Phone: (Home) ______________

Work: _____________________

City: ______________________ State: _____________________

Zip Code: __________________

Name ______________________

Phone: (Home) ______________

Work: ______________________

City: _______________________ State: ______________________

Zip Code: ___________________

Affidavit: I verify that the above information regarding insurance is accurate and complete. I understand that the intentional furnishing of incorrect information via the US Mail may be fraudulent and violate federal laws as well as state laws.

Parent/Guardian Signature________________________________
Date: ________________

Authorization: I hereby authorize any physician or hospital who has treated or attended to the above claimant to furnish the insurance company or its representative any information requested. A photocopy of this authorization is to be considered valid.

Signature of Insured (Parent or Guardian is claimant is under 18)____

Date: ________________