Adventist Risk Management, Inc.

12501 Old Columbia Pike
Silver Spring, MD 20904-6600
(301) 680-6877 Fax: (301) 680-6878

VOLUNTEER LABOR – POLICY SRG 9019830

Most Seventh-day Adventist conferences and institutions carry Volunteer Labor Accident insurance for their members. This limited **excess policy** will pay for covered medical costs that occur as a result of an accident "while performing all voluntary labor and services for an insured institution." The insurance is for one year **from the date of accidental injury**, subject to a maximum benefit. This insurance is payable only in **excess of any expenses payable by other valid and collectible group insurance**, which means it pays only for covered medical expenses not paid by your own group insurance, or a plan through your employer, or government. The policy provides "a weekly accident indemnity when as the result of injury the insured person is totally and continuously disabled and prevented from performing each and every duty pertaining to his occupation and volunteer work." A death benefit is also provided should life be lost due to the volunteer-related accident.

A volunteer is described as a person "participating in any scheduled, sponsored and supervised activity." If you were being paid for any work done for the church, you should submit this accident claim to the Worker's compensation department for your State.

In order to properly and completely process a volunteer labor claim, the following checked items should be provided:

___________ Letter from church pastor, head elder or conference employee verifying **accident occurred while you were participating in a scheduled, sponsored and supervised volunteer activity, or traveling to or from such activity.**

___________ **"Accident and Sickness Claim Form"** completed on both sides signed by you and your attending physician.

___________ Itemized medical bills

___________ Statement from your insurance company showing how much they paid (or denial of benefits). This includes Medicare Explanation of Benefits.

If you lost wages due to this accident:

___________ Fully completed and signed **"Supplementary Statement for Continuing Disability Under Accident Policy"** claim form with **Attending Physician Supplementary Statement.**

___________ Statement of wages from employer for two months preceding accident.

Send this information to the above address – Attention: Mary Cross. The claim will be filed with

American International Companies to be processed under the terms of the policy. Should you have any questions, call (301) 680-6877, or 1-800-638-0589.

INSURANCE COMPANY OF THE STATE OF PENNSYLVANIA

MAIL TO:

Mary Cross
Adventist Risk Management, Inc.
12501 Old Columbia Pike
Silver Spring, MD 20904

Phone: (301) 680-6877 Fax: (301) 680-6878

NAME OF GROUP: General Conference of Seventh-day Adventists
12501 Old Columbia Pike, Silver Spring, MD 20904

POLICY NUMBER: **SRG 9019830**

SPECIAL RISK ACCIDENT AND SICKNESS CLAIM FORM

INSTRUCTIONS:

1) You must have SECTION A fully completed by a designated official of the Policyholder.
2) SECTION B is to be completed, signed and dated by the claimant or parent/guardian of claimant, if claimant is a minor.
3) If claimant is treated in the hospital, please attach an itemized hospital bill.
4) If claimant is treated by a doctor, have the doctor complete the Physician's Statement or attach an itemized bill.
5) Attach itemized bills for all medical expenses being claimed including the claimant's name, condition being treated (diagnosis), description of services, date of service(s) and the charge made for each service.
6) Please mail completed form and bills to above address.

The furnishing of this form, or its acceptance by the Company, must not be construed as an admission of any liability on the Company, nor a waiver of any of the conditions of the insurance contract.
Any person who knowingly and/or with intent to injure, defraud, or deceive an insurance company or other person files a statement of claim containing false, incomplete or misleading information, may be guilty of insurance fraud and subject to criminal and substantial civil penalties.

SECTION A

LOCATION OF GROUP POLICYHOLDER
Maryland

CLAIMANT'S FULL NAME	SOCIAL SECURITY NO. (IF AVAILABLE)	DATE OF BIRTH	NAME OF SUPERVISOR

DATE COVERAGE BEGAN	DATE COVERAGE WILL EN/HAS ENDED
NATURE OF INJURY OR ILLNESS (DESCRIBE FULLY , INCLUDING WHICH PART OF BODY WAS INJURED)	DESCRIBE HOW, WHEN AND WHERE ACCIDENT OCCURRED (DATE AND TIME)

NAME OF ACTIVITY INDICATE THE SPORT (IF APPLICABLE)	DID ACCIDENT OCCUR:		
	A. WHILE CLAIMANT WAS SUPERVISE	☐ YES	☐ NO
	B DURING SPONSORED ACTIVITY	☐ YES	☐ NO
	C DURING PROGRAMMED HOURS	☐ YES	☐ NO
	D WHILE TRAVELING TO OR FROM REGULARLY SCHEDULED ACTIVITY IN A SUPERVISED GROUP	☐ YES	☐ NO

DATE LAST WORKED	DATE RETURNED TO WORK	WEEKLY EARNINGS

POLICYHOLDER REPRESENTATIVE (PLEASE PRINT OR TYPE) TITLE	DAYTIME TELEPHONE NUMBER ( )
SIGNATURE OF POLICYHOLDER REPRESENTATIVE	DATE

SECTION B

NAME OF CLAIMANT (PARENT OR GUARDIAN IF A MINOR)	DAYTIME TELEPHONE NO. ( )

ADDRESS OF CLAIMANT (PARENT OR GUARDIAN IF A MINOR)

OTHER THEALTH INSURANCE COVERAGE (ENTER NAME OF INSURED, NAME AND ADDRESS OF INSURANCE COMPANY NAME OF EMPLOYER AND POLICY NUMBER)
☐ YES ☐ NO

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

SIGNATURE (CLAIMANT OR PARENT, IF CLAIMANT IS A MINOR)

AUTHORIZATION

I, the undersigned authorize any hospital or other medical-care institution, physician or other medical professional, pharmacy, insurance support organization, governmental agency, group policyholder, insurance company, association, employer or benefit plan administrator to furnish to the Insurance Company named above or its representative, any and all information with respect to any injury or sickness suffered by, the medical history of, or any consultation, prescription or treatment provided to, the person whose death, injury, sickness or loss is the basis of claim and copies of all of that person's hospital or medical records, including information relating to mental illness and use of drugs and alcohol, to determine eligibility for benefit payments under the Policy Number identified above. I authorize the group policyholder, employer or benefit plan administrator to provide the Insurance Company named above with financial and employment-related information. I understand that this authorization is valid for the term of coverage of the Policy identified above and that a copy of this authorization shall be considered as valid as the original. I understand that I or my authorized representative may request a copy of this authorization.

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

SIGNATURE **DATE**

I hereby certify that the above information is true and correct to the best of my knowledge and belief.

SIGNATURE DATE

SECTION B **HEALTH INSURANCE CLAIM FORM**

CLAIMANT INFORMATION

1. MEDICARE (Medicare *) MEDICAID (Medicaid) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File *) GROUP HEALTH PLAN (SSN or ID) FECA BLKLUNG (SSN) OTHER		1A. INSURED'S I.D. NUMBER (ID)
2. PATIENT'S NAME (First Name, Middle Initial, Last Name	3. PATIENT'S DATE OF BIRTH MM DD YY / / / SEX M F	4. INSURED'S NAME (First Name, Middle Initial, Last Name)
5. PATIENT'S ADDRESS (No. Street)	6. PATIENT'S RELATIONSHIP TO INSURED SELF SPOUSE CHILD OTHER (Specify)	7. INSURED'S ADDRESS (No. Street)
CITY STATE	8. PATIENT STATUS	CITY STATE

9. OTHER INSURED'S NAME

A. OTHER INSURED'S POLICY OR GROUP NUMBER

B. OTHER INSURED'S DATE OF SEX
MM DD YY
/ / / M F

C. EMPLOYER'S NAME OR SCHOOL NAME

D. INSURANCE PLAN NAME OR PROGRAM NAME

10. IS PATIENT'S CONDITION RELATED TO:
A. PATIENT'S EMPLOYMENT?
YES NO

B. AN AUTO ACCIDENT?
YES NO

C. OTHER ACCIDENT?
YES NO

D. RESERVED FOR LOCAL USE

11. INSURED'S POLICY GROUP OR FECA NUMBER

3. PATIENT'S DATE OF BIRTH SEX
MM DD YY
/ / / M F

EMPLOYER'S NAME OR SCHOOL NAME

C. INSURANCE PLAN NAME OR PROGRAM NAME

D. IS THERE ANOTHER HEALTH BENEFIT PLAN?
YES NO

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE
I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below

Signatures Date

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE
I authorize payment of medical benefits to undersigned physician or supplier for service described below

Signature Date

14. DATE OF CURRENT OR
MM DD YR
OR
/ /
(LMP)
ILLNESS (First symptom)
INJURY (Accident)
PREGNANCY

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS
GIVE FIRST DATE: MM DD YR
/ /

16. Dates Patient Unable To Work in Current Occupation
MM / DD / YY MM / DD / YY
FROM / / TO / /

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. Hospitalization Dates Related to Current Services
MM / DD / YY MM / DD / YY
FROM / / TO / /

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? $ CHARGES
YES NO

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE)

1 ________________ _________ ___________

2 ________________ _________ ___________

3 ________________

4 ________________

22. MEDICAID RESUBMISSION
CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24 A	B	C	D	E	F	G	H	I	J	K
DATE(S) OFERVICE FROM TO MM/DD/YY MM/DD/YY	PLACE OF SERVICE	TYPE OF SERVICE	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CP/HCPCS MODIFIER	DIAGNOSIS CODE	$ CHARGES	DAYS OR UNITS	DPSDT Family Plan	EMG	COB	RESERVED FOR LOCAL USE

25. FEDERAL TAX NUMBER
SSN EIN

26. PATIENT'S ACCOUNT .NO

27. ACCEPT ASSIGNMENT
YES NO

28. TOTAL CHARGES
$

29. AMOUNT PAID
$

30. BALANCE DUE
$

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS
(I certify that the statements apply to this bill and are made a part thereof)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE #

PIN # GRP #

PLACE OF SERVICE CODES

1-(H) – INPATIENT HOSPITAL
2- (OH) – OUTPATIENT HOSPITAL
3-(O) – DOCTOR'S OFFICE
4-(H) PATIENT'S HOME
5 – DAYCARE FACILITY (PSY)
6- NIGHT CARE FACILITY(PSY)
7-(NH) NURSING HOME
8- (SNF)-SKILLED NURSING FACILITY
9- - AMBULANCE
O-(OL)-OTHER LOCATIONS
A-(IL)-INDEPENDENT LABORATORY
B- OTHER

Insurance Company of the State of Pennsylvania
MAIL TO:
Mary Cross
Adventist Risk Management, Inc.
12501 Old Columbia Pike Phone: (301) 680-6877
Silver Spring, MD 20904 FAX (301) 680-6878

NAME OF GROUP: General Conference of Seventh-day Adventists

POLICY NUMBER: **SRG 9019830**

SUPPLEMENTARY STATEMENT FOR CONTINUING DISABILITY UNDER ACCIDENT POLICY

The furnishing of this blank shall not be held to be a waiver of any breach of any or the conditions of the policy.

Social Security No. ______ Policy Number SRG 9019830 Claim Number ______

Full Name ______ Telephone Number ______

Street Address ______ City ______ State and Zip ______

(Please attach a statement of your wages from your employer for the past two months)

1. On what dates since the last statement furnished by you were you treated by a physician? ______

Names and addresses of current attending physicians ______

2. Were you hospitalized since the last statement? (Yes or No) ______ From ______ To ______

3. For what period were you continuously disabled according to the following definitions?
   TOTAL DISABILITY means inability to perform each and every duty pertaining to any business or occupation.
   Totally and continuously from ______ 20 ____ A.M. P.M. Through ______ 20 ____ A.M. P.M.
   PARTIAL DISABILITY means ability to perform one or more important duties of one's occupation.
   Partially and continuously from ______ 20 ____ A.M. P.M. Through ______ 20 ____ A.M. P.M.

   Have you received disability benefits from your employer because of your injury? ______

4. Have you retired from your business or occupation? (Yes or No) ______ If yes, when? ______ 20 ____

5. If your total disability has not terminated, when do you anticipate that it will? ______

I, the undersigned do hereby warrant the foregoing answers and statements to be complete and true.

I hereby authorize any hospital, physician or other person who has attended me, or any employer, to furnish the American International Companies or its representatives, any and all information with respect to any sickness or injury medical history, consultation, prescription, or treatment, copies of all hospital or medical records and copies of all records of employers. I agree that a photo static copy of this authorization shall be considered as effective and valid as the original.

Signature ______ Date ______
(CLAIMANT OR INSURED)

ATTENDING PHYSICIAN'S SUPPLEMENTARY STATEMENT

Patient's Name ______

1. (a) Nature of sickness or injury and complications, if any, causing onset of this period of total disability? ______

   (b) Explain subsequent complications, if any, which have or are now affecting this period of total disability? ______

2. What operations, if any were performed? ______

3. Give all dates of treatment since last statement: ______ Home ______ Office ______

4. Was patient hospitalized since last statement? (Yes or No) ______ From ______ To ______

   Name and address of hospital? ______

5. Have any other physicians been in attendance or in consultation since last statement?
   If so, give their names and addresses ______

6. How long was or will patient be totally and continuously disabled?
   TOTAL DISABILITY means inability to perform each and every duty pertaining to any business or occupation.
   Totally and continuously from ______ 20 ____ A.M. P.M. Through ______ 20 ____ A.M. P.M.
   PARTIAL DISABILITY means ability to perform one or more important duties of one's occupation.
   Partially and continuously from ______ 20 ____ A.M. P.M. Through ______ 20 ____ A.M. P.M.

7. (a) If Patient is still totally disabled, when do you anticipate that his total disability will terminate?
   Approximate Date ______ 20 ____ or if unknown, approximate number of months ____ years ____

   (b) If permanent total disability explain ______

Signature ______ M.D. Date ______ Telephone No. ______

Insurance Company of the State of Pennsylvania DISMEMBERMENT/PARALYSIS

MAIL TO:

Mary Cross
Adventist Risk Management, Inc.
12501 Old Columbia Pike Phone: (301) 680-6877
Silver Spring, MD 20904 FAX (301) 680-6878

NAME OF GROUP: General Conference of Seventh-day Adventists
POLICY NUMBER: **SRG9019830**

GROUP POLICYHOLDER/EMPLOYER INSTRUCTIONS

In order to assure prompt processing of this claim, please forward the claim form to the Claimant. The Employer/Administrator must complete PART A in its entirety. Due to recent changes in tax laws, the Claimant will be required to complete PART B. Be certain that PARTS C and D on the reverse side are completed in full and signed by the Claimant and Attending Physician, respectively. The Claimant is responsible for the completion of the Attending Physician's Statement without expense to the Company.

Return this form to the above address.

In addition to the claim form, the following items are required:
(1) Your company's enrollment benefits form; (2) Confirmation of employee's principal sum and current premium payment; (3) information on other insurance; (4) If Business Travel, a copy of employee's itinerary prior to the accident, purpose of the trip, destination to and from trip, and confirmation that trip was authorized by the company.
Please provide company name, address, phone number, and policy number.
Every question must be fully answered. We reserve the right to require or to obtain further information should it be deemed necessary.

Any person who knowingly and/or with intent to injure, defraud, or deceive an insurance company or other person files a statement of claim containing false, incomplete or misleading information, may be guilty of insurance fraud and subject to criminal and substantial civil penalties.

PART A: GROUP POLICYHOLDER/EMPLOYER INFORMATION

GROUP POLICYHOLDER/EMPLOYER ADDRESS

DIVISION NAME AND ADDRESS	DATE EMPLOYED
EMPLOYEE/MEMBER NAME AND ADDRESS	DATE OF ACCIDENT

EFFECTIVE DATE OF COVERAGE	EMPLOYEE/MEMBER SOCIAL SECURITY NUMBER	DATE OF BIRTH	EMPLOYEE/MEMBER OCCUPATION

TERMINATION DATE OF COVERAGE TO	INSURANCE CLASS	SALARY ON DATE LAST WORKED (HRLY/WKLY/MTHLY/ANNLY)	DATE PREMIUM PAID

ACCIDENTAL DEATH BENEFIT IN FORCE	DATE OF LAST BENEFIT INCREASE	IS EMPLOYEE/MEMBER RECEIVING W.C. BENEFITS? _ YES _ NO	IS EMPLOYEE/MEMBER RECEIVING ANY OTHER INSURANCE? _ YES _ NO

IF EITHER ANSWER IS YES, INDICATE NAME OF COMPANY:	ADDRESS OF COMPANY

POLICY NUMBER	PHONE NUMBER	TYPE OF BENEFIT, BENEFIT AMOUNT, EFFECTIVE DATE

STATUS OF EMPLOYEE/MEMBER ON DATE LAST WORKED
_ ACTIVE _ RETIRED _ PREMIUM WAIVER FOR DISABILITY _ APPROVED LEAVE OF ABSENCE (EXPLAIN) _ OTHER

DATE EMPLOYEE/MEMBER LAST WORKED	REASON EMPLOYEE/MEMBER DID NOT RETURN TO WORK

EMPLOYEE/MEMBER WAS: _ HOURLY _ SALARIED _ COMMISSIONED _ OTHER (EXPLAIN)

If Claim is For Dependent, Provide the Following:

DEPENDENT'S NAME AND ADDRESS	SOCIAL SECURITY NUMBER	RELATIONSHIP	AMOUNT OF BENEFIT

DEPENDENT'S OCCUPATION	DEPENDENT'S DATE OF BIRTH	NAME AND ADDRESS OF EMPLOYER

GROUP POLICYHOLDER/EMPLOYER SIGNATURE

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

DATE SIGNED	PLACE (CITY, STATE)	PHONE NUMBER

GROUP POLICYHOLDER/EMPLOYER	BY (THEIR AUTHORIZED REPRESENTATIVE)

PART B: IMPORTANT TAX INFORMATION

To Be Completed by Claimant
Social Security Number/
Tax ID Number

Please Print or Type Name of Claimant

Under penalties of perjury, I certify: (1) that the Social Security/Tax ID Number shown above is my correct Social Security or Taxpayer Identification Number.

Be Certain Part C on the Reverse Side is Completed

PART C: CLAIMANT INFORMATION

WHEN DID ACCIDENT HAPPEN? (DESCRIBE FULLY) DESCRIBE INJURIES RECEIVED.

NAME | ADDRESS | PHONE NUMBER

LIST ALL WITNESSES TO ACCIDENT

NAME | ADDRESS | PHONE NUMBER

NAME | ADDRESS | PHONE NUMBER

AUTHORIZATION

I, the undersigned authorize any hospital or other medical-care institution, physician or other medical professional, pharmacy, insurance support organization, governmental agency, group policyholder, insurance company, association, employer or benefit plan administrator to furnish to the Insurance Company named above or its representatives any and all information with respect to any injury or sickness suffered by, the medical history of, or any consultation, prescription or treatment provided to, the person whose death, injury, sickness or loss is the basis of claim and copies of all that person's hospital or medical records, including information relating to mental illness and use of drugs and alcohol, to determine eligibility for benefit payments under the Policy Number identified above. I authorize the group policyholder, employer or benefit plan administrator to provide the Insurance Company named above with financial and employment-related information. I understand that this authorization is valid for the term of coverage of the Policy identified above and that a copy of this authorization shall be considered as valid as the original. I understand that I or my authorized representative may request a copy of this authorization.

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

SIGNATURE OF CLAIMANT OR AUTHORIZED REPRESENTATIVE | DATE SIGNED (MONTH, DAY, YEAR)

ADDRESS OF CLAIMANT, OR AUTHORIZED REPRESENTATIVE (NO., STREET, CITY, STATE) | BUSINESS PHONE NUMBER ( ) | HOME PHONE NUMBER ( )

PART D: ATTENDING PHYSICIAN'S STATEMENT

THE CLAIMANT IS RESPONSIBLE FOR THE COMPLETION OF THIS STATEMENT WITHOUT EXPENSE TO THE COMPANY.

NAME OF PATIENT | AGE | ADDRESS (STREET, CITY, STATE, ZIP CODE)

NATURE OF INJURY (DESCRIBE COMPLICATIONS, IF ANY)

WHEN DID ACCIDENT HAPPEN? (MO., DAY, YEAR) | WHEN DID PATIENT FIRST CONSULT YOU FOR THIS CONDITION? (MO. DAY, YEAR)

DID THE ACCIDENTAL INJURY RESULT IN:

LOSS OF HANDS?	_ RIGHT _ LEFT	WAS SEVERANCE AT OR ABOVE WRIST JOINT?	_ YES _ NO	DATE OF SEVERANCE	EXTANT OF SEVERANCE
LOSS OF THUMB AND FINGER OF SAME HAND?	_ RIGHT _ LEFT	WAS SEVERANCE THROUGH OR ABOVE METACARPOPHALANGEAL JOINT?	_ YES _ NO	DATE OF SEVERANCE	EXTANT OF SEVERANCE
LOSS OF FEET?	_ RIGHT _ LEFT	WAS SEVERANCE AT OR ABOVE ANKLE JOINT?	_ YES _ NO	DATE OF SEVERANCE	EXTANT OF SEVERANCE

TOTAL AND IRRECOVERABLE LOSS OF SIGHT OF:

RIGHT EYE _ YES _ NO DATE OF LOSS____________ WAS EYE REMOVED? _ YES _ NO DATE REMOVED__________

LEFT EYE _ YES _ NO DATE OF LOSS____________ WAS EYE REMOVED? _ YES _ NO DATE REMOVED__________

TOTAL AND IRRECOVERABLE LOSS OF HEARING IN BOTH EARS? _ YES _ NO DATE OF LOSS

IN YOUR OPINION, WAS ANY DISEASE, INFECTION, BODILY OR MENTAL INFIRMITY AN UNDERLYING CAUSE IN THE LOSS(ES) INDICATED ABOVE?

IN YOUR OPINION, DID THE LOSS(ES) RESULT FROM ANY SELF-INFLICTED INJURY OR ATTEMPTED SELF-DESTRUCTION? _ YES _ NO

IF THE INDICATED LOSS(ES) INCLUDE LOSS OF SIGHT, PLEASE ANSWER THE FOLLOWING QUESTIONS:

IF THE LOSS OF SIGHT IS PARTIAL, BUT IRRECOVERABLE, PLEASE STATE AMOUNT OF VISION IN EACH EYE WITH SNELLEN NOTATIONS, OR JAEGER SCALE IF PERTINENT.

UNCORRECTED: O.D. O.S. | CORRECTED: O.D. O.S. | DATE OF EXAMINATION

DO YOU BELIEVE VISION CAN BE RESTORED IN WHOLE OR IN PART BY TREATMENT OR OPERATION? _ YES _ NO

IF AN OPERATION IS CONTEMPLATED, GIVE APPROXIMATE DATE.

WAS PATIENT CONFINED TO A HOSPITAL? _ YES _ NO IF "YES", GIVE NAME AND ADDRESS OF HOSPITAL.

TREATMENT

DATE OF FIRST VISIT | DATES OF SUBSEQUENT VISITS

SIGNATURE OF ATTENDING PHYSICIAN | PHYSICIAN'S NAME (PLEASE PRINT) | DEGREE | TELEPHONE ( ) | DATE

STREET ADDRESS | CITY OR TOWN | STATE OR PROVINCE | ZIP CODE

IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? _ YES _ NO

IF DISCHARGED, GIVE DATE OF DISCHARGE:

American International Companies ®

Insurance Company of the State of Pennsylvania

PROOF OF LOSS – ACCIDENTAL DEATH

MAIL TO:

Mary Cross
Adventist Risk Management, Inc.
12501 Old Columbia Pike
Silver Spring, MD 20904

Phone: (301) 680-6877
FAX (301) 680-6878

NAME OF GROUP: General Conference of Seventh-day Adventists

POLICY NUMBER: **SRG9019830**

GROUP POLICYHOLDER/EMPLOYER INSTRUCTIONS

In order to assure prompt processing of this claim, please forward the claim form to the Beneficiary. The Employer/Administrator must complete PART A in its entirety. Due

In addition to the claim form, the following items are required:
(1) A Certified Copy of the final death certificate;
(2) Your company's enrollment benefits form and Beneficiary Designation;
(3) Confirmation of employee's Principal Sum and current premium payment;
(4) The Police Report, any Autopsy Report, and any newspaper clippings.
(5) If Business Travel, a copy of employee's itinerary prior to the accident, purpose of the trip, destination to and from trip, and confirmation that trip was authorized by the company.

Every question must be fully answered. We reserve the right to require or to obtain further information should it be deemed necessary. If there is more than one beneficiary, all may join in one statement, or a separate form will be furnished for each if desired.

PART A: GROUP POLICYHOLDER/EMPLOYER INFORMATION

GROUP POLICYHOLDER/EMPLOYER ADDRESS

DIVISION NAME AND ADDRESS	ACCIDENTAL DEATH BENEFIT IN FORCE $

EMPLOYEE'S NAME AND ADDRESS	DATE EMPLOYED	DATE OF BIRTH

EFFECTIVE DATE OF COVERAGE	SOCIAL SECURITY NUMBER	DATE OF DEATH	OCCUPATION

TERMINATION DATE OF COVERAGE TO	INSURANCE CLASS	SALARY ON DATE LAST WORKED (HRLY/WKLY/MTHLY/ANNLY)	DATE PREMIUM PAID

DATE LAST WORKED	STATUS ON DATE LAST WORKED
	_ ACTIVE _ RETIRED _ PREMIUM WAIVER FOR DISABILITY _ APPROVED LEAVE OF ABSENCE (EXPLAIN) _ OTHER

EMPLOYEE WAS: _ HOURLY _ SALARIED _ COMMISSIONED _ OTHER (EXPLAIN)

If Claim is For Dependent, Provide the Following:

DEPENDENT'S NAME AND ADDRESS	SOCIAL SECURITY NUMBER	RELATIONSHIP	AMOUNT OF BENEFIT

DEPENDENT'S OCCUPATION	DEPENDENT'S DATE OF BIRTH	NAME AND ADDRESS OF EMPLOYER

GROUP POLICYHOLDER/EMPLOYER SIGNATURE

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

DATE SIGNED	PLACE (CITY, STATE)	PHONE NUMBER

GROUP POLICYHOLDER/EMPLOYER	BY (THEIR AUTHORIZED REPRESENTATIVE)

PART B: IMPORTANT TAX INFORMATION

To Be Completed by Beneficiary
Social Security Number/
Tax ID Number

Please Print or Type Name of Claimant

Under penalties of perjury, I certify: (1) that the Social Security/Tax ID Number shown above is my correct Social Security or Taxpayer Identification Number.

Be Certain Part C on the Reverse Side is Completed

PART C: BENEFICIARY INFORMATION

In order to assure prompt processing, please be certain the authorization below is signed by the beneficiary. The completed and signed claim form along with the Certified Death Certificate, Police Report, Autopsy Report, and any newspaper clippings should be returned to the Employer/Administrator.

NAME OF BENEFICIARY	RELATIONSHIP TO DECEDENT	BENEFICIARY'S DATE OF BIRTH

NOTE: If any designated beneficary is deceased, submit that beneficiary's certified Death Certificate. If the beneficiary is the Deceased's estate, furnish certified letters of Administration or Letters of Testamentary, and Estate Tax ID Number. If the beneficiary is a minor, furnish certified Letters of Guardianship for the minor's estate and minor's social security number.

WHEN DID ACCIDENT HAPPEN? (MONTH, DAY, YEAR)	TIME _ A.M. _ P.M.	WHERE DID ACCIDENT HAPPEN? (IF CITY OR TOWN, SHOW STREET NUMBER)

WHEN DID SYMPTOMS OF CAUSE OF DEATH FIRST APPEAR?

HOW DID ACCIDENT HAPPEN? (DESCRIBE FULLY)

LIST ALL PHYSICIANS AND SURGEONS WHO ATTENDED DECEASED FOR THESE INJURIES CAUSING DEATH.

NAME & ADDRESS	NAME & ADDRESS	NAME & ADDRESS

LIST ALL PHYSICIANS AND SURGEONS WHO ATTENDED DECEASED DURING THE LAST FIVE YEARS (STATE AILMENTS INVOLVED).

NAME	ADDRESS	AILMENT
NAME	ADDRESS	AILMENT

LIST ALL WITNESSES TO ACCIDENT.

NAME & ADDRESS	NAME & ADDRESS	NAME & ADDRESS

LIST OTHER COVERAGES AND AMOUNTS OF INSURANCE IN FORCE ON DECEASED'S LIFE.

NAME OF COMPANY	POLICY NUMBER	EFFECTIVE DATE	AMOUNT OF INSURANCE
NAME OF COMPANY	POLICY NUMBER	EFFECTIVE DATE	AMOUNT OF INSURANCE

HAVE DIVORCE PROCEEDINGS EVER BEEN INSTITUTED BY OR AGAINST THE DECEASED? IF YES, INDICATE WHEN, WHERE AND THE OUTCOME.

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

AUTHORIZATION

I, the undersigned authorize any hospital or other medical-care institution, physician or other medical professional, pharmacy, insurance support organization, governmental agency, group policyholder, insurance company, association, employer or benefit plan administrator to furnish to the Insurance Company named above or its representatives any and all information with respect to any injury or sickness suffered by, the medical history of, or any consultation, prescription or treatment provided to, the person whose death, injury, sickness or loss is the basis of claim and copies of all that person's hospital or medical records, including information relating to mental illness and use of drugs and alcohol, to determine eligibility for benefit payments under the Policy Number identified above. I authorize the group policyholder, employer or benefit plan administrator to provide the Insurance Company named above with financial and employment-related information. I understand that this authorization is valid for the term of coverage of the Policy identified above and that a copy of this authorization shall be considered as valid as the original. I understand that I or my authorized representative may request a copy of this authorization.

For claimants not residing in California, New York, or Pennsylvania: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

SIGNATURE OF BENEFICIARY, AUTHORIZED REPRESENTATIVE, OR NEXT OF KIN	DATE SIGNED (MONTH, DAY, YEAR)	
ADDRESS OF NEXT OF KIN (NO., STREET, CITY, STATE)	BUSINESS PHONE NUMBER ( )	HOME PHONE NUMBER ( )