

**PROOF OF LOSS**

**AMERICAN INTERNATIONAL COMPANIES ®**  
**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:** **9023048 – MISCELLANEOUS ACCIDENT MEDICAL**

**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	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	B DURING SPONSORED ACTIVITY	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	C DURING PROGRAMMED HOURS	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	D WHILE TRAVELING TO OR FROM REGULARLY SCHEDULED ACTIVITY IN A SUPERVISED GROUP	<input type="checkbox"/> YES	<input type="checkbox"/> 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) <input type="checkbox"/> YES <input type="checkbox"/> 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

1. MEDICARE <input type="checkbox"/> (Medicare *)		MEDICAID <input type="checkbox"/> (Medicaid)		CHAMPUS <input type="checkbox"/> (Sponsor's SSN)		CHAMPVA <input type="checkbox"/> (VA File #)		GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID)		FECA BLKLUNG <input type="checkbox"/> (SSN)		OTHER		1A. INSURED'S I.D. NUMBER <input type="checkbox"/> (ID)	
2. PATIENT'S NAME (First Name, Middle Initial, Last Name)				3. PATIENT'S DATE OF BIRTH MM / DD / YY				SEX M <input type="checkbox"/> F <input type="checkbox"/>				4. INSURED'S NAME (First Name, Middle Initial, Last Name)			
5. PATIENT'S ADDRESS (No. Street)				6. PATIENT'S RELATIONSHIP TO INSURED SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER <input type="checkbox"/> (Specify)				7. INSURED'S ADDRESS (No. Street)							
CITY		STATE		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>				CITY		STATE					
ZIP CODE		TELEPHONE NO.		9. OTHER INSURED'S NAME				ZIP CODE		TELEPHONE NO.					
A. OTHER INSURED'S POLICY OR GROUP NUMBER				10. IS PATIENT'S CONDITION RELATED TO: A. PATIENT'S EMPLOYMENT? YES <input type="checkbox"/> NO <input type="checkbox"/>				11. INSURED'S POLICY GROUP OR FECA NUMBER							
B. OTHER INSURED'S DATE OF MM / DD / YY				SEX M <input type="checkbox"/> F <input type="checkbox"/>				3. PATIENT'S DATE OF BIRTH MM / DD / YY				SEX M <input type="checkbox"/> F <input type="checkbox"/>			
C. EMPLOYER'S NAME OR SCHOOL NAME				B. AN AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>				EMPLOYER'S NAME OR SCHOOL NAME							
D. INSURANCE PLAN NAME OR PROGRAM NAME				C. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>				C. INSURANCE PLAN NAME OR PROGRAM NAME							
				D. RESERVED FOR LOCAL USE				D. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/>							

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

14. DATE OF CURRENT OR ILLNESS (First symptom) MM / DD / YR		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 TO 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 TO MM / DD / YY FROM / / TO / /	

19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? \$ CHARGES YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE)		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.	
1 _____ 3 _____			
2 _____ 4 _____		23. PRIOR AUTHORIZATION NUMBER	

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

25. FEDERAL TAX NUMBER SSN <input type="checkbox"/> BIN <input type="checkbox"/>		26. PATIENT'S ACCOUNT NO.		27. ACCPT ASSIGNMENT <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGES \$		29. AMOUNT PAID \$		30. BALANCE DUE \$	
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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)		33. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE #	
SIGNED		DATE		PIN #	
				GRP #	

PLACE OF SERVICE CODES		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	
1-(H) - INPATIENT HOSPITAL 2-(OH) - OUTPATIENT HOSPITAL 3-(O) - DOCTOR'S OFFICE							