IF POSSIBLE, ATTACH PHYSICIAN'S STATEMENT AND/ORITEMIZED BILLING TO THIS FORM. HOWEVER,DO NOT WAIT FOR MEDICAL STATEMENT TO SUBMIT CLAIM FORM. COPY CLAIM FORM FOR YOUR RECORDS.

ADVENTIST RISK MANAGEMENT, INC.
Attn: Risk Management Department
19800 Oatfield Road * Gladstone, OR 97027 * O (503) 850-3500 * F (503) 850-3453

MEDICAL PAYMENTS CLAIM FORM
(ED. 7/2010)

CONFERENCE:				
CHURCH & ADDRESS:				
(1) Person's Last Name First Name M.I.		Date of Birth	Sex	Name of Parent of Guardian, if minor
(2) Person's Address (Street, City, State, Zip Code)		**Telephone #:**		
Date of Accident: _____ **Time of Accident:** _____		**Social Security # (mandatory per Federal law):** _____ - _____ - _____ ☐ I do not have a Social Security # / No tengo Seguro Social Signature / Firma _____		
(3) Nature of Injury/Sickness (fracture, sprain, etc.)				
(4) How did accident occur? Please give details				

LOCATION OF ACCIDENT _____ **DATE ACCIDENT REPORTED** _____

(5) **Did accident occur during: (check yes or no)**	**Yes**	**No**	**Type of Activity**	
Church Function			Name of Leader	Title of Leader
Conference Sponsored Event			Time Activity Commenced	Time Activity Dismissed
VBS				
Pathfinders				
Camp			Name & Address of Witness	Daytime Phone
Other				
While Supervised				
During Sponsored Activity			Name & Address of Witness	Daytime Phone
During programmed hours				
On activity premises				
While traveling to or from an activity in an authorized automobile			Name & Address of Witness	Daytime Phone
In the course of your employment				

I hereby certify that the statements made above are correct to the best of my knowledge and I believe that the above claimant was covered hereunder at the time of the accident/sickness.

Signature of Supervisory Official _____ Title _____ Date _____