Incident Report Form

AMERICAN INCOME LIFE insurance company — SPECIAL RISK DIVISION

AIL OFFICE USE ONLY:
CL#________________
SC:________________
L#:________________

PART 1

Policy # ____________

Serial # ______________ Dates Person Was Insured________________

Name of Policy Holder/Group______________________________________

PART 2

Name of Patient ____

Patient Date of Birth _______________________ **Age** ______ **Sex** M F

Home Address of Patient ____

City ____ **State**________ **Zip**__________

Patient is:

- ☐ Camper/Member
- ☐ Counselor/Instruct.
- ☐ Salaried Staff Eligible Work Comp.
- ☐ Summer Staff
- ☐ Volunteer Leader

INJURY- ILLNESS REPORT

PART 3

Date of Injury/ Illness: Time: Group Activity:

Nature of Injury or Illness: Was this condition already present before this person became insured? ☐ Yes ☐ No

Describe How and Where Injury Occurred (explain fully): *If yes, please explain*

If there was no medical treatment during insured period, was injury or illness reported to staff member? ☐ ***Yes*** ☐ ***No***

Office Use:

Verification Signature

PART 4

This form is to be completed by the Camp Director, Chaperone, or Group Leader of the Event - UNRELATED to patient

I hereby certify that this was a supervised group activity sponsored by the organization covered under this policy.

I was the: ☐ Camp Director ☐ Chaperone ☐ Group Leader ☐ Extension Personnel ☐ Other (define) ______________________

Contact (**Print Name**)____ Title: ____________________________

Signed:____

Name of Camp/Org. ______________________________________ Day Time Phone: ______________________________

For prompt service please attach all itemized bills for services rendered (doctor, hospital and prescriptions).

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

ASSIGNMENT FORM – Receipts must be enclosed

ONLY COMPLETE IF MEDICAL BILLS HAVE BEEN PAID BY PATIENT/GUARDIAN

PART 5

I hereby authorize the American Income Life Insurance Company to reimburse eligible medical benefits on the above claim to:

(Payee Name) ____ is to be reimbursed.

Address ____ City _______________________________ State _________ Zip ____________

Phone #: ______________________________ Email: ____

Date ______________________ Signed_______________________________________

FOR MEDICAL RELEASE AUTHORIZATION: COMPLETE REVERSE SIDE

AMERICAN INCOME LIFE insurance company SPECIAL RISK DIVISION

Release of Medical Information Authorization

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I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, that has any records of me or my health, to give to the American Income Life Insurance Company or its reinsurers any such information with respect to illness, injury, medical history, consultation, or treatments which include alcohol, drug or chemical dependency treatment. Information received is for the purpose of evaluating this claim and determining our liability under your existing coverage with American Income Life Insurance Company. This authorization shall remain valid for one year. You have the right to receive a copy of this authorization upon request. A photographic copy of this authorization shall be as valid as the original.

____ __________________________
Signature of Patient/Guardian/ or Personal Representative Date

How to File a Claim

1. Written notice of claim or Claim Report must be given to the company within twenty days of commencement of any loss covered by this policy *or as soon as is reasonably possible.*

2. All claim reports must be completed and signed by the camp director, chaperone, or group leader who is UNRELATED TO THE PATIENT. Report the following:

   1. Name of the injured/ill person (patient).
   2. Patient's Date of Birth
   3. Date of the incident (for either an injury or an illness).
   4. How injury/illness was sustained.
   5. Signature for Medical Information Authorization

3. Please provide:

   A. Complete medical diagnosis by the attending physician.
   B. Itemized statements for services rendered by physician or hospital.
   C. Prescription receipts complete with patients name, Rx number, name of prescription, and price.
   D. Proof of payment with an itemized bill if payment has been made.

Payment is made directly to the medical provider unless otherwise indicated on Part 5.

Mail or Fax this Claim Report directly to company. DO NOT rely on medical providers to forward this Claim Report.

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Special Risk Division
P.O. Box 50158
Indianapolis, IN 46250
Ph: 800-849-4820
Fax: 317-849-2793
Web: www.americanincomelife.com

All correspondence will be directed to the policyholder.