



NORTH AMERICAN DIVISION MEDICAL PAYMENTS STATEMENT OF LOSS

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TO BE COMPLETED BY CHURCH ORGANIZATION

CONFERENCE:

CHURCH NAME:

CHURCH ADDRESS:

CITY:

STATE:

ZIP CODE:

CHURCH CONTACT PERSON:

TELEPHONE | BUSINESS:

RESIDENTIAL:

EMAIL ADDRESS:

▶ ABOUT THE INJURED PERSON:

FIRST NAME:

M.I.

LAST NAME:

DATE OF BIRTH:
(MM/DD/YYYY)

SOCIAL SECURITY #:

MALE FEMALE

ADDRESS:

CITY:

STATE:

ZIP CODE:

TELEPHONE | BUSINESS:

RESIDENTIAL:

EMAIL ADDRESS:

NAME OF PARENT / GUARDIAN*:

DATE OF ACCIDENT:
(MM/DD/YYYY)

TIME OF ACCIDENT:

AM

PM

DESCRIBE THE INJURY:

HOW DID ACCIDENT HAPPEN?:

LOCATION OF ACCIDENT - ADDRESS:

CITY:

STATE:

ZIP CODE:

DATE ACCIDENT REPORTED:
(MM/DD/YYYY)

TYPE OF ACTIVITY:

TIME OF ACTIVITY - COMMENCED:

DISMISSED

DOES THE INJURED PERSON HAVE OTHER INSURANCE?

YES NO

OTHER INSURANCE NAME:

OTHER INSURANCE - ADDRESS:

CITY:

STATE:

ZIP CODE:

▶ DID THE ACCIDENT OCCUR DURING:

ACTIVITY - LEADER:

DURING SPOURED ACTIVITY:

YES NO

TITLE:

DURING PROGRAMMED HOURS:

YES NO

CHURCH FUNTION:

YES NO

CAMP:

YES NO

ON ACTIVITY PREMISES:

YES NO

VACATION BIBLE SCHOOL:

YES NO

OTHER:

YES NO

WHILE TRAVELING TO OR FROM AN ACTIVITY IN AN AUTHORIZED AUTOMOBILE:

YES NO

PATHFINDER:

YES NO

WHILE SUPERVISED:

YES NO

IN THE COURSE OF YOUR EMPLOYMENT:

YES NO

▶ WITNESSES:

FIRST NAME:

TELEPHONE | BUSINESS:

RESIDENTIAL:

ADDRESS:

CITY:

STATE:

ZIP CODE:

FIRST NAME:

TELEPHONE | BUSINESS:

RESIDENTIAL:

ADDRESS:

CITY:

STATE:

ZIP CODE:

FIRST NAME:

TELEPHONE | BUSINESS:

RESIDENTIAL:

ADDRESS:

CITY:

STATE:

ZIP CODE:

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

▶ SIGNATURE OF SUPERVISORY OFFICIAL:

DATE (MM/DD/YYYY):

ATTACH PHYSICIAN'S STATEMENT AND/OR ITEMIZED BILLING TO THIS FORM