AMERICAN INCOME LIFE insurance company

SPECIAL RISK DIVISION

P.O. Box 50158
Indianapolis, IN 46250
800-849-4820
Fax: 317-849-2793

This form is to be completed by the County Office of the registered member/leader, or Group Leader of the Event.

CLAIM REPORT

PART 1

Policy # A IN48180 **INDIANA STATE 4-H PRGM- PURDUE UNIV.**

Name of County Office:_______________ **Mailing Address:**_______________

Agent/Contact: _______________ _______________

Phone Number: _______________

PART 2

Name of Patient _______________

Patient Date of Birth _______________ **Age** ________ **Sex** **M** **F**

Home Address of Patient _______________

City _______________ **State**________ **Zip**__________

Patient is:

☐ 4-H Member

☐ 4-H Leader

PART 3

INJURY REPORT	ILLNESS REPORT
Date of Injury: Time:	Date Insured First Noticed Symptoms:
Group Activity:	Nature of Illness:
Describe How and Where Injury Occurred (**explain fully**):	Was this condition already present before this person became insured? ☐ Yes ☐ No If YES, please explain:
Office Use:	*Office Use:*

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

Verification Signature - UNRELATED to patient

PART 4

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

I am the: ☐ Agent/Educator ☐ Club Leader ☐ Other (define) _______________

Contact (Print Name)_______________ Title: _______________

Signed:_______________

Name of County/Club. _______________ Day Time Phone: _______________

ASSIGNMENT FORM

PART 5

I hereby authorize the American Income Life Insurance Company to pay benefits on the above claim to:

☐ Medical Provider(s) [Check is sent directly to the facility providing the medical services.]

☐ (Payee Name) _______________ is to be reimbursed. **Receipts must be enclosed**

Address _______________ City _______________ State ______ Zip __________

Date _______________ Signed_______________