



VOLUNTEER LABOR

Most Seventh-day Adventist conferences and institutions carry Volunteer Labor Accident insurance for their members. This limited **excess policy** will pay for covered medical costs that occur as a result of an accident “while performing all voluntary labor and services for an insured institution.” The insurance is for one year **from the date of accidental injury**, subject to a maximum benefit. This insurance is payable only in **excess of any expenses payable by other valid and collectible group insurance**, which means it pays only for covered medical expenses not paid by your own group insurance, or a plan through your employer, or government.

A volunteer is described as a person “participating in any scheduled, sponsored and supervised activity.” If you were being paid for any work done for the church, you should submit this accident claim to the Worker’s compensation department for your State.

In order to properly and completely process a volunteer labor claim, the following checked items should be provided:

_____ Letter from church pastor, head elder or conference employee verifying **accident occurred while you were participating in a scheduled, sponsored and supervised volunteer activity, or traveling to or from such activity.**

_____ **“Accidental Dismemberment/Paralysis Claim Form”** completed on both sides signed by you and your attending physician.

_____ Itemized medical bills

_____ Statement from your insurance company showing how much they paid (or denial of benefits). This includes Medicare Explanation of Benefits.

Send this information to the above address. The claim will be filed by ARM Claims with American International Companies to be processed under the terms of the policy. Should you have any questions, call (301) 680-6870.

Adventist Risk Management, Inc.
 12501 Old Columbia Pike
 Silver Spring, MD 20904
 Email: claims@adventistrisk.org

Phone: (301) 680-6870
 FAX (301) 680-6878

NAME OF GROUP:
POLICY NUMBER:

GROUP POLICYHOLDER/EMPLOYER INSTRUCTIONS

In order to assure prompt processing of this claim, please forward the claim form to the Claimant. The Employer/Administrator must complete PART A in its entirety. Due to recent changes in tax laws, the Claimant will be required to complete PART B. Be certain that PARTS C and D on the reverse side are completed in full and signed by the Claimant and Attending Physician, respectively. The Claimant is responsible for the completion of the Attending Physician's Statement without expense to the Company.

Return this form to the above address.

In addition to the claim form, the following items are required:

(1) Your company's enrollment benefits form; (2) Confirmation of employee's principal sum and current premium payment; (3) information on other insurance; (4) If Business Travel, a copy of employee's itinerary prior to the accident, purpose of the trip, destination to and from trip, and confirmation that trip was authorized by the company.

Please provide company name, address, phone number, and policy number.

Every question must be fully answered. We reserve the right to require or to obtain further information should it be deemed necessary.

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.

PART A: GROUP POLICYHOLDER/EMPLOYER INFORMATION

GROUP POLICYHOLDER/EMPLOYER ADDRESS

DIVISION NAME AND ADDRESS			DATE EMPLOYED	
EMPLOYEE/MEMBER NAME AND ADDRESS			DATE OF ACCIDENT	
EFFECTIVE DATE OF COVERAGE	EMPLOYEE/MEMBER SOCIAL SECURITY NUMBER	DATE OF BIRTH	EMPLOYEE/MEMBER OCCUPATION	
TERMINATION DATE OF COVERAGE	INSURANCE CLASS	SALARY ON DATE LAST WORKED (HRLY/WKLY/MTHLY/ANNLY)		DATE PREMIUM PAID TO
ACCIDENTAL DEATH BENEFIT IN FORCE	DATE OF LAST BENEFIT INCREASE BENEFITS?	IS EMPLOYEE/MEMBER RECEIVING W.C. OTHER INSURANCE? <input type="checkbox"/> YES <input type="checkbox"/> NO	IS EMPLOYEE/MEMBER RECEIVING ANY <input type="checkbox"/> YES <input type="checkbox"/> NO	
IF EITHER ANSWER IS YES, INDICATE NAME OF COMPANY:		ADDRESS OF COMPANY		
POLICY NUMBER	PHONE NUMBER	TYPE OF BENEFIT, BENEFIT AMOUNT, EFFECTIVE DATE		
STATUS OF EMPLOYEE/MEMBER ON DATE LAST WORKED				
<input type="checkbox"/> ACTIVE <input type="checkbox"/> RETIRED <input type="checkbox"/> PREMIUM WAIVER FOR DISABILITY <input type="checkbox"/> APPROVED LEAVE OF ABSENCE (EXPLAIN) <input type="checkbox"/> OTHER				
DATE EMPLOYEE/MEMBER LAST WORKED	REASON EMPLOYEE/MEMBER DID NOT RETURN TO WORK			
EMPLOYEE/MEMBER WAS:	<input type="checkbox"/> HOURLY <input type="checkbox"/> SALARIED <input type="checkbox"/> COMMISSIONED <input type="checkbox"/> OTHER (EXPLAIN)			

If Claim is For Dependent, Provide the Following:

DEPENDENT'S NAME AND ADDRESS	SOCIAL SECURITY NUMBER	RELATIONSHIP	AMOUNT OF BENEFIT
DEPENDENT'S OCCUPATION	DEPENDENT'S DATE OF BIRTH	NAME AND ADDRESS OF EMPLOYER	

GROUP POLICYHOLDER/EMPLOYER SIGNATURE

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

DATE SIGNED	PLACE (CITY, STATE)	PHONE NUMBER
GROUP POLICYHOLDER/EMPLOYER		BY (THEIR AUTHORIZED REPRESENTATIVE)

PART B: IMPORTANT TAX INFORMATION

To Be Completed by Claimant
 Social Security Number/
 Tax ID Number

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Claimant

 Please Print or Type Name of

Under penalties of perjury, I certify: (1) that the Social Security/Tax ID Number shown above is my correct Social Security or Taxpayer Identification Number. Be Certain Part C on the Reverse Side is Completed

PART C: CLAIMANT INFORMATION

WHEN DID ACCIDENT HAPPEN? (DESCRIBE FULLY) DESCRIBE INJURIES RECEIVED.

LIST ALL PHYSICIANS AND SURGEONS WHO ATTENDED EMPLOYEE/MEMBER FOR THESE INJURIES

NAME	ADDRESS	PHONE NUMBER
NAME	ADDRESS	PHONE NUMBER

LIST ALL WITNESSES TO ACCIDENT

NAME	ADDRESS	PHONE NUMBER
NAME	ADDRESS	PHONE NUMBER

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 representatives, 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 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 OF CLAIMANT OR AUTHORIZED REPRESENTATIVE	DATE SIGNED (MONTH, DAY, YEAR)	
ADDRESS OF CLAIMANT, OR AUTHORIZED REPRESENTATIVE (NO., STREET, CITY, STATE)	BUSINESS PHONE NUMBER ()	HOME PHONE NUMBER ()

PART D: ATTENDING PHYSICIAN'S STATEMENT

THE CLAIMANT IS RESPONSIBLE FOR THE COMPLETION OF THIS STATEMENT WITHOUT EXPENSE TO THE COMPANY.

NAME OF PATIENT	AGE	ADDRESS (STREET, CITY, STATE, ZIP CODE)

NATURE OF INJURY (DESCRIBE COMPLICATIONS, IF ANY)

WHEN DID ACCIDENT HAPPEN? (MO., DAY, YEAR)	WHEN DID PATIENT FIRST CONSULT YOU FOR THIS CONDITION? (MO. DAY, YEAR)

DID THE ACCIDENTAL INJURY RESULT IN:

LOSS OF HANDS?	<input type="checkbox"/> RIGHT <input type="checkbox"/> LEFT	WAS SEVERANCE AT OR ABOVE WRIST JOINT?	<input type="checkbox"/> YES <input type="checkbox"/> NO	DATE OF SEVERANCE	EXTANT OF SEVERANCE	
LOSS OF THUMB AND FINGER OF SAME HAND?	<input type="checkbox"/> RIGHT <input type="checkbox"/> LEFT	WAS SEVERANCE THROUGH OR ABOVE METACARPOPHALANGEAL JOINT?	<input type="checkbox"/> YES <input type="checkbox"/> NO	DATE OF SEVERANCE	EXTANT OF SEVERANCE	
LOSS OF FEET?	<input type="checkbox"/> RIGHT <input type="checkbox"/> LEFT	WAS SEVERANCE AT OR ABOVE ANKLE JOINT?	<input type="checkbox"/> YES <input type="checkbox"/> NO	DATE OF SEVERANCE	EXTANT OF SEVERANCE	
TOTAL AND IRRECOVERABLE	RIGHT EYE	<input type="checkbox"/> YES <input type="checkbox"/> NO	DATE OF LOSS _____	WAS EYE REMOVED?	<input type="checkbox"/> YES <input type="checkbox"/> NO	DATE REMOVED _____
LOSS OF SIGHT OF:	LEFT EYE	<input type="checkbox"/> YES <input type="checkbox"/> NO	DATE OF LOSS _____	WAS EYE REMOVED?	<input type="checkbox"/> YES <input type="checkbox"/> NO	DATE REMOVED _____
TOTAL AND IRRECOVERABLE LOSS OF HEARING IN BOTH EARS?	<input type="checkbox"/> YES <input type="checkbox"/> NO		DATE OF LOSS			

IN YOUR OPINION, WAS ANY DISEASE, INFECTION, BODILY OR MENTAL INFIRMITY AN UNDERLYING CAUSE IN THE LOSS(ES) INDICATED ABOVE?

IN YOUR OPINION, DID THE LOSS(ES) RESULT FROM ANY SELF-INFLICTED INJURY OR ATTEMPTED SELF-DESTRUCTION? YES NO

IF THE INDICATED LOSS(ES) INCLUDE LOSS OF SIGHT, PLEASE ANSWER THE FOLLOWING QUESTIONS:

IF THE LOSS OF SIGHT IS PARTIAL, BUT IRRECOVERABLE, PLEASE STATE AMOUNT OF VISION IN EACH EYE WITH SNELLEN NOTATIONS, OR JAEGER SCALE IF PERTINENT.

UNCORRECTED	CORRECTED	DATE OF EXAMINATION
O.D.	O.S.	O.D.
DO YOU BELIEVE VISION CAN BE RESTORED IN WHOLE OR IN PART BY TREATMENT OR OPERATION? <input type="checkbox"/> YES <input type="checkbox"/> NO		
IF AN OPERATION IS CONTEMPLATED, GIVE APPROXIMATE DATE.		
WAS PATIENT CONFINED TO A HOSPITAL? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF "YES", GIVE NAME AND ADDRESS OF HOSPITAL.	

TREATMENT

DATE OF FIRST VISIT	DATES OF SUBSEQUENT VISITS			
SIGNATURE OF ATTENDING PHYSICIAN	PHYSICIAN'S NAME (PLEASE PRINT)	DEGREE	TELEPHONE ()	DATE
STREET ADDRESS	CITY OR TOWN	STATE OR PROVINCE	ZIP CODE	

IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? YES NO

IF DISCHARGED, GIVE DATE OF DISCHARGE: