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

SPECIAL RISK DIVISION

American Income Life Insurance Co.

CLAIM REPORT

PART 1

Policy # 4843

Serial # N/A

Policy Holder: Louisiana State University

Name of Camp/Club/Group ____________

Dates Person Was Insured ____________

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

PART 2

Name of Patient ____________

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

Home Address of Patient ____________

City ____________ **State**________ **Zip**________

Patient is:
- ☐ Camper/Member/ Student
- ☐ Counselor/Instruct.
- ☐ Salaried Staff Eligible Work Comp.
- ☐ Summer Staff
- ☐ Volunteer 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***

PART 4

Verification Signature - 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 ☐ Other (define) ____________

Contact (Print Name)____________ Title: ____________

Signed:____________

Name of Camp/Org. ____________ Day Time Phone: ____________

PART 5

ASSIGNMENT FORM

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____________

Rev 12/11