NORTH AMERICAN DIVISION MEDICAL PAYMENTS STATEMENT OF LOSS

Central California Conference of SDA
2820 Willow Avenue, Clovis, CA 93612
OFFICE: (559) 347-3000
Submit Completed Form to: propandriskmgmt@cccsda.org

TO BE COMPLETED BY CHURCH ORGANIZATION

CONFERENCE: Central California

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:

TITLE:

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:	☐ ☐ NO	WHILE SUPERVISED:	☐ YES ☐ NO	IN THE COURSE OF YOUR EMPLOYMENT:	☐ YES ☐ NO

DURING SPOSORED ACTIVITY: ☐ YES ☐ NO

DURING PROGRAMMED HOURS: ☐ 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