

## **J. Pekala & Associates**

110 Kimberly Way Hatfield, PA 19440  
(215) 721 – 5753 (888) 829-6505 Fax (215) 723-7866  
[www.churchinsurers.com](http://www.churchinsurers.com)

### **Student Medical Claim Report**

Please furnish the following information for prompt handling of your claim. You may call this information in our office or you may fax or mail this form to us.

#### **Policyholder Information**

Insured's Name (as it appears on policy) \_\_\_\_\_

DBA: \_\_\_\_\_

Insured's Address 1 (Street) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Policy No. \_\_\_\_\_ Policy Effective Date: \_\_\_\_\_

Date reported: \_\_\_\_\_

Contact (Name): \_\_\_\_\_ Title \_\_\_\_\_

Phone (Home) \_\_\_\_\_ (Work) \_\_\_\_\_

Phone (Church) \_\_\_\_\_ Fax \_\_\_\_\_

E-Mail \_\_\_\_\_

Date of Accident \_\_\_\_\_ Time of Accident \_\_\_\_\_ am \_\_\_\_\_ pm \_\_\_\_\_

#### **Accident Information**

Location of Accident (Street) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Description of Accident- Describe fully-Include rough sketch if possible. (Use additional paper if necessary)

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### **Injured Person Information**

Name of Injured Person: \_\_\_\_\_

Age \_\_\_\_\_ Sex \_\_\_\_\_ DOB: \_\_\_\_\_ Social Security # \_\_\_\_\_

Grade: \_\_\_\_\_

Parent/Guardian of minor child \_\_\_\_\_

Address (Street) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone (Home) \_\_\_\_\_ (Work) \_\_\_\_\_

Was the accident school related? \_\_\_\_\_

Did the accident occur: (Please Circle)

- a) while the claimant was supervised? Y or N
- b) during sponsored activity? Y or N
- c) during programmed hours? Y or N
- d) on activity premises? Y or N
- e) while traveling directly and uninterruptedly to or from home premises and school for regular school sessions or school sponsored and supervised activities? Y or N

Are you insured under any medical accident policy ? Y or N

If yes, please provide policy number and

Company: \_\_\_\_\_

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Injuries claimed: \_\_\_\_\_

Physicians Name: \_\_\_\_\_

Address (Street) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Name of Facility where injured was taken \_\_\_\_\_

Address (Street) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Was injured transported by Ambulance? \_\_\_ No \_\_\_ Yes

**Witnesses (Use Additional Paper if Necessary)**

It is critical to give full name and address of every person who knows anything about the accident.

Name \_\_\_\_\_

Phone: (Home) \_\_\_\_\_

Work: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Zip Code: \_\_\_\_\_

Name \_\_\_\_\_

Phone: (Home) \_\_\_\_\_

Work: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Zip Code: \_\_\_\_\_

**Affidavit:** I verify that the above information regarding insurance is accurate and complete. I understand that the intentional furnishing of incorrect information via the US Mail may be fraudulent and violate federal laws as well as state laws.

Parent/Guardian Signature \_\_\_\_\_  
Date: \_\_\_\_\_

**Authorization:** I hereby authorize any physician or hospital who has treated or attended to the above claimant to furnish the insurance company or its representative any information requested. A photocopy of this authorization is to be considered valid.

Signature of Insured (Parent or Guardian is claimant is under 18) \_\_\_\_\_

Date: \_\_\_\_\_