RISK MANAGEMENT SELF-INSURANCE FUND CLAIM FORM

Medical

Answer ALL questions below. Attach all medical bills and primary insurance company Explanation of Benefits (EOB) to this form.

Mail To: Presbyterian Church (USA), Office of Risk Management, 100 Witherspoon Street
Room 5623, Louisville, Ky. 40202

Name________________________________ Date______________________

Type of Volunteer: Mission Co-Worker_____ Short Term . _____ Long Term_____ YAV____

SIF Enrollment Dates: Eff.______________ to ________________

Assignment:____

Permanent Mailing Address ____
____
____

Date of Injury/Illness______________________________

Diagnosis or Nature of Illness
____
____

Name of Primary Insurance Company:____

MEDICAL AUTORIZATION SECTION MUST BE SIGNED BY THE PARTICIPANT

I hereby authorize any hospital, doctor, or other person who has attended me or examined me to furnish to Presbyterian Church (USA) any and all information with respect to any illness, medical history, consultation, prescriptions or treatment, and copies of all hospital medical records. A Photostat copy of this authorization shall be considered as effective and valid as the original.

Signature:____ Date:_______________

FINANCIAL RESPONSIBILITY

I understand that I am financially responsible for charges not covered by the Self Insurance Fund.

Signature:_______________________________________ Date:________________

Comments/Notes: