SEVENTH-DAY ADVENTIST® CHURCH
Oregon Conference

HOW TO FILE A CLAIM

19800 Oatfield Road
Gladstone, OR 97027-2546
Telephone: 503-850-3500
Fax: 503-654-5657
www.OregonConference.org

MEDICAL PREMISES

CLAIM INFORMATION
IMMEDIATE AND TIMELY REPORTING IS CRITICAL

DOCUMENTATION NEEDED: *(TO ACCOMPANY COMPLETED CLAIM FORM)*

- If an attorney is involved, provide name and address.
- Have papers been served? If so, when? Attach a copy.
- Copies of medical bills, if any.

ADDITIONAL DOCUMENTATION NEEDED FOR MEDICAL PROFESSIONAL LIABILITY SITUATIONS:

- Medical Records
- Incident Report
- Any statements by medical personnel.

PROCEDURE:

Please send above information to Oregon Conference Risk Management. ARM may assign an adjuster in complex situations, it is important for you to cooperate with them. If there are any problems, let us know immediately.

INFORMATION SHOULD BE SENT BY MAIL, EMAIL OR FAX:

Oregon Conference of Seventh-day Adventist
Attn: Risk Management
19800 Oatfield Road
Gladstone, OR 97027

Wendy Kessler, Administrative Assistant, Risk Management
OFFICE: (503) 850-3553 - FAX: (503) 850-3453
EMAIL: wendy.kessler@oc.npuc.org

Or

Simona Cardwell, Director, Risk Management
OFFICE: (503) 850-3522 - FAX: (503) 850-3422
EMAIL: simona.cardwell@oc.npuc.org

NORTH AMERICAN DIVISION MEDICAL PAYMENTS STATEMENT OF LOSS

12501 Old Columbia Pike - Silver Spring, MD 20904
OFFICE: (301) 680-6870 | **FAX:** (301) 680-6878
EMAIL: claims@adventistrisk.org

TO BE COMPLETED BY CHURCH ORGANIZATION

CONFERENCE:

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