This [illegible] to b[illegible]

CLAIM REPORT

P A R T 1

Name of Patient _____ Patient is:

Sex M F

☐ [illegible]per/Member/Student
☐ Counselor/Instruct.
☐ Salaried Staff

☐ [illegible] Comp
☐ Summer Staff
☐ Volunteer Leader

Patient Date of Birth _____ Age _____

Home Address of Pa[illegible]

City _____ State _____ Zip _____

K T 2

Nature of Illness:

Describ[illegible]

Was this condition already [illegible] before this person became [illegible]sured? ☐ Yes ☐ No

K T 3

[illegible] Use Use:

[illegible] staff member? [illegible]

Verification Signa[illegible] UNRELATED

[illegible]ored by the organization covered under this policy.

P A R T 4

I hereby certify that this [illegible] supervised gro[illegible]

Leader ☐ Other (define) _____

I was the: ☐ Camp Director ☐ [illegible] ☐ Grou[illegible]

Title: _____

Contact (Print Name) _____

Signed: [illegible]

[illegible] directly to the facility [illegible]

[illegible]imbursed. [illegible]