JPA
NON-PROFIT INSURANCE SPECIALISTS
110 KIMBERLY WAY
HATFIELD, PA 19440
OFFICE: 1-888-829-6505
FAX: 215-721-5753
NONPROFITINSURERS.COM

Camper 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)

_____

_____

_____

_____

Injured Person Information

Name of Injured Person: _____

Age _____ Sex _____ DOB:_____ Social Security #_____

Parent/Guardian of minor child _____

Address (Street) _____

City _____ State _____ Zip Code _____

Phone (Home) _____ (Work) _____

Was the accident camp 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

Are you insured under any medical accident policy ? Y or N
If yes, please provide policy number and Company Information:

_____

_____

_____

_____

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 U.S. 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: _____