Girl Scouts of the USA Claim Form

Mail any additional bills (properly identified by injured person and council name) to:

Special Risk Services
P.O. Box 31156
Omaha, Nebraska 68131
1-800-524-2324

Claimant Information – All Questions Must Be Answered

Name of claimant | Age | Date of Birth

Claimant's address | Number and Street | City | State | ZIP Code

If claimant is a minor, name of parent or guardian | Phone Number ( ) -

Address of parent or guardian | Number and Street | City | State | ZIP Code

Father, Guardian or Claimant's (if adult) Employer's Name and Address: _____

_____ Phone No. (_____) _____ - _____

Mother, Guardian or Spouse's Employer's Name and Address: _____

_____ Phone No. (_____) _____ - _____

Name of all companies providing your insurance coverage or prepaid health plans.

Name of Company | Address | Policy or Certificate No.

_____

_____

If you do not have other coverage, sign and date the following statement.

I, _____, on _____, verify there is no other insurance coverage available for these and all expenses related to this claim.

I hereby certify that all above information is true and complete.

I verify that I have read and understand the fraud statement for my state that accompanied this form.

New York Claimants: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION. (PURSUANT TO 11 NYC RR86)

_____ _____

Signature (Parent/Guardian) | Date

ATTACH ITEMIZED BILLS WITH A DOCTOR'S DIAGNOSIS

GIRL SCOUT LEADER STATEMENT

Troop Number _____

Level: 0 ☐ Daisy 1 ☐ Brownie 2 ☐ Junior 3 ☐ Cadette 4 ☐ Senior 5 ☐ Adult member 6 ☐ Nonmember child 7 ☐ Nonmember adult 8 ☐ Staff 9 ☐ Seasonal Staff 51 ☐ Ambassador

Name of council | Council No. | Phone Number ( ) -

Council's address | Number and Street | City | State | ZIP Code

Date and place of accident or sickness	Date and location	Nature and details of injury or sickness

Activity information

Type of activity (check below):

1. ☐ Autos/Vehicles
   - ☐ Driver
   - ☐ Passenger
   - ☐ Pedestrian
2. ☐ Slips/Falls on/at/over/from
   - ☐ Equipment/Furniture
   - ☐ Animals
   - ☐ Other (carpet, log, stairs, etc.)
3. ☐ Using Tools
   - ☐ Saw
   - ☐ Knife
   - ☐ Stove
   - ☐ Kiln
   - ☐ Other
4. ☐ Aquatics (in/on water)
   - ☐ Swimming/diving
   - ☐ Boating/canoeing
   - ☐ Water Skiing
5. ☐ Poisonous Plants/Insects (poison ivy/bee stings)
6. ☐ Skating
   - ☐ Roller
   - ☐ Ice
7. ☐ Illness/Sickness
8. ☐ Other Accident

Overnight events

Was this an overnight event? ☐ Yes ☐ No If "Yes," number of nights _____

Name of event:

Indicate dates of attendance from to

Troop validation or authorized activity representative's validation

We hereby certify that the insured person is a currently registered Girl Scout or that the required premium for insurance coverage has been paid for this person and that the claimant was participating in an authorized Girl Scout activity as described above.

_____

Activity Representative's Signature/Troop Leader's Signature Date

_____

Street Address City State ZIP Code

Did injury occur during course of employment? ☐ Yes ☐ No

Claims covered by the council's workers' compensation policy should not be submitted to Mutual of Omaha.

COUNCIL USE ONLY

I certify that this injury or sickness occurred as described and that the activity was sponsored and supervised by the Girl Scouts.

_____

Council Official's Signature Date

Authorization for Release of Information

I authorize Mutual of Omaha Insurance Company and/or its affiliated companies to disclose my or my children's personal information to Girl Scouts USA for purposes of claim confirmation.

The personal information may include such items as claim and medical information, including diagnosis, mental and physical condition, prescription drug records, and other related claim information.

I understand that I may refuse to sign this authorization. My refusal to sign will not affect my enrollment, my eligibility for benefits or my ability to obtain payment, but may delay the processing of my claim.

If the person or entity to whom information is disclosed isn't a health care provider or health plan subject to federal privacy regulations, the information may be redisclosed without the protection of the federal privacy regulations.

Unless revoked earlier, this authorization will remain in effect for 24 months from the date I sign it. I understand that I may revoke this authorization at any time, by written notice to: Mutual of Omaha Insurance Company, ATTN: Special Risk Claims, PO Box 31156, Omaha, NE 68131.

I understand that I am entitled to receive a copy of the signed authorization.

_____ _____

Signature Date

_____

Relationship to insured