GIRL SCOUTS OF THE U.S.A.
CLAIM FORM

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

Special Risk Services
United of Omaha Life Insurance Company
P.O. Box 31156
Omaha, Nebraska 68131
1-800-524-2324

CLAIMANT INFORMATION — ALL QUESTIONS MUST BE ANSWERED

Claim is made under the following Plan:

___ Plan 1 – Basic Coverage
___ Plan 2 – Participant Accident
___ Plan 3E – Extended Event
___ Plan 3P – Extended Event
___ Plan 3PI – International Extended Event
___ International Inbound

Enrollment Request ID: _____
(Applicable to Optional Coverages only)

Name of claimant | Identification Number | 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

If your organization has selected coverage containing a Nonduplication amount, the benefits will be considered as follows: The Nonduplication amount, as stated in your selected coverage, of medically necessary services and supplies can be paid regardless of other insurance coverage. For expenses over the Nonduplication amount, or if you expect the total to exceed the Nonduplication amount, you must submit to your primary insurance carrier. We require their Explanation of payment even if it is applied to your deductible. If Denied, send a copy of your denial notice. Include itemized bills.

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.

Signature (Parent/Guardian) _____ **Date** _____

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

ATTACH ITEMIZED BILLS WITH A DOCTOR'S DIAGNOSIS

OVER →

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 United 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 the Mutual of Omaha Insurance Company and/or its affiliated companies to disclose my or my children's personal information to Girl Scouts U.S.A. 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 is not 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, Mutual of Omaha Plaza, Omaha, NE 68175.

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

_____ _____

Signature **Date**

_____

Relationship to Insured