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



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







	CLAIMANT INFORMATION — ALL QUESTIONS MUST BE ANSWERED									
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	Phone Number	er								
			()	-						
Address of parent or guardian	Number and Street	City	State	ZIP Code						
in your selected coverage, of amount, or if you expect the t	medically necessary services and state to exceed the Nonduplication a	cation amount, the benefits will be considupplies can be paid regardless of other in amount, you must submit to your primary your denial notice. Include itemized bills	surance coverage. For expenses ov insurance carrier. We require their	er the Nonduplication						
Father, Guardian or Claimant	's (if adult) Employer's Name and A	ddress:								
			Phone No. ()							
Mother, Guardian or Spouse'	s Employer's Name and Address:									
			Phone No. ()							
	ling your insurance coverage or pre	paid health plans. Address	Dallan an Cant	icianta Na						
ľ	Name of Company	Address	Policy or Cert	ilicate No.						
I,expenses related to this claim	rage, sign and date the following st , on n. e information is true and complete.	tatement, verify there is no	o other insurance coverage availabl	le for these and all						
Signature (Parent/Guardian)		Date								
Authorization for Rele	ase of Information									
I authorize the Mutual of information to Girl Scot	of Omaha Insurance Companits U.S.A. for purposes of cla	y and/or its affiliated companies im confirmation.	to disclose my or my childre	n's personal						
	on may include such items as drug records, and other relat	s claim and medical information, ed claim information.	including diagnosis, mental	and physical						
	refuse to sign this authoriza payment, but may delay the p	tion. My refusal to sign will not af processing of my claim.	fect my enrollment, my eligi	bility for benefits						
		sed is not a health care provider hout the protection of the federal		leral privacy						
	y time, by written notice to: I	n in effect for 24 months from the Mutual of Omaha Insurance Comp								
I understand that I am e	entitled to receive a copy of t	he signed authorization.								
Signature		 Date								
Relationship to Insured										

Name of Council No.	GIRL SCOUT LEA	DER STATEMENT		0 Daisy			7 Nonmember Adult	
Name of Council's address Number and Street City State ZIP Code Date and place of accident or sickness Type of activity (check below): 1. Autos/Vehicles 2. Slips/Falls on/at/over/from 3. Using Tools 4. Aquatics (in/on water) Saw Swimming/Diving Roller	Troop Number		Level:					
Council's address Number and Street City State ZiP Code	Name of Counci	1						
Date and place of accident or sickness Type of activity (check below):	Name of Counci	l			Council No.	Pnone Nu	mper	
Date and place of accident or sickness Type of activity (check below):						()	-	
of accident or sickness Type of activity (check below):	Council's addres	SS Number and	l Street		City	State	ZIP Code	
Activity information Activity information	Date and place of accident or sickness	Date and location			Nature and details of	injury or sickness		
Overnight events Name of event:	Activity information	1. Autos/Vehicles 2. Driver Passenger	Slips/Fa	nipment/Furniture mals er (carpet, log,	☐ Saw ☐ Knife ☐ Stove ☐ Kiln	Swimming/Diving Boating/Canoeing Water Skiing Poisonous Plants/Insects	Roller Lice 7. Illness/Sickness	
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 Activity Representative's Signature/Troop Leader's Signature Date Date	Overnight events	Name of event:						
tive's validation 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. I certify that this injury or sickness occurred as described and that the activity was sponsored and supervised by the Girl Scouts. COUNCIL USE ONLY State ZIP Code Claim is made under the following Plan: Plan 1 - Basic Coverage Plan 2 - Participant Accident Plan 3E - Extended Event Plan 3P - Extended Event Plan 3P - Extended Event	Troop validation or authorized activity representa- tive's validation						coverage has been paid for	
Street Address 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. I certify that this injury or sickness occurred as described and that the activity was sponsored and supervised by the Girl Scouts. COUNCIL USE ONLY State ZIP Code Claim is made under the following Plan: Plan 1 - Basic Coverage Plan 2 - Participant Accident Plan 3E - Extended Event Plan 3P - Extended Event Plan 3P - International Extended Event		Activity Representative's Signature/Tro	oop Leader's Sig	nature			Date	
Claims covered by the Council's workers' compensation policy should not be submitted to United of Omaha. I certify that this injury or sickness occurred as described and that the activity was sponsored and supervised by the Girl Scouts. COUNCIL USE ONLY Claim is made under the following Plan: Plan 1 - Basic Coverage Plan 2 - Participant Accident Plan 3E - Extended Event Plan 3P - Extended Event Plan 3P - International Extended Event		Street Address			City	State	ZIP Code	
Plan 1 - Basic Coverage Plan 2 - Participant Accident		Did injury occur during cours	e of employ	ment? 🗌 Yes 🔲 No				
COUNCIL USE ONLY I certify that this injury of sickness occurred as described and that the activity was sponsored and supervised by the Girl Scouts. Plan 3E - Extended Event Plan 3P - Extended Event Plan 3PI - International Extended Event		Claims covered by the Council's workers' compensation				 □ Plan 1 - Basic Coverage □ Plan 2 - Participant Accident □ Plan 3E - Extended Event □ Plan 3P - Extended Event □ Plan 3PI - International Extended Event 		
Council Official's Signature Date International Inbound	COUNCIL USE ONLY				d that the			
		Council Official's Signature Date				☐ International Inbound		

Fraud Statements

The following fraud language is attached to, and made part of this claim form. Please read and do not remove these pages from this claim form.

- ** Alaska: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.
- ** Arizona: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.
- ** Arkansas or Louisiana: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
- ** California: For your protection California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.
- ** Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.
- ** **Delaware:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.
- ** **District of Columbia:** WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.
- ** Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

- ** **Idaho:** Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.
- ** Indiana: A person who knowingly and with intent to defraud an insurer, files a statement of claim containing any false, incomplete, or misleading information, commits a felony.
- ** **Kentucky:** Any person who knowingly and with intent to defraud any insurance company or other person files a 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.
- ** Maine, Tennessee, Virginia or Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and a denial of insurance benefits.
- ** Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.
- ** New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.
- ** New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.
- ** New Mexico: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.
- ** New York: 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)
- ** Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.
- ** Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete, or misleading information is guilty of a felony.
- ** Pennsylvania: 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 subjects such person to criminal and civil penalties.
- ** Puerto Rico: Any person who knowingly, and with intent to defraud or deceive any insurance company includes false information in an application for insurance or files, assists, or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefits, or files more than one claim for the same loss or damage, may be guilty of a felony. Upon conviction, that person will be fined between \$5,000 and \$10,000, imprisoned for three (3) years or both. Aggravating or attenuating circumstances may result in the prison term being increased to five (5) years or reduced to two (2) years.
- ** Texas: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.
- ** If you live in a state other than mentioned above, the following statement applies to you:

 Any person who knowingly, and with intent to injure, defraud or deceive any insurer or insurance company, files a statement of claim containing any materially false, incomplete, or misleading information or conceals any fact material thereto, may be guilty of a fraudulent act, may be prosecuted under state law and may be subject to civil and criminal penalties. In addition, any insurer or insurance company may deny benefits if false information materially related to a claim is provided by the claimant.