

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

GIRL SCOUT LEADER STATEMENT

Troop Number _____

Level:

0 ☐ Daisy
1 ☐ Brownie
2 ☐ Junior3 ☐ Cadette
4 ☐ Senior
5 ☐ Adult member6 ☐ Nonmember child
7 ☐ Nonmember adult
8 ☐ Staff9 ☐ 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. <input type="checkbox"/> Autos/Vehicles <input type="checkbox"/> Driver <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian	2. <input type="checkbox"/> Slips/Falls on/at/over/from <input type="checkbox"/> Equipment/Furniture <input type="checkbox"/> Animals <input type="checkbox"/> Other (carpet, log, stairs, etc.)	3. <input type="checkbox"/> Using Tools <input type="checkbox"/> Saw <input type="checkbox"/> Knife <input type="checkbox"/> Stove <input type="checkbox"/> Kiln <input type="checkbox"/> Other	4. <input type="checkbox"/> Aquatics (in/on water) <input type="checkbox"/> Swimming/diving <input type="checkbox"/> Boating/canoeing <input type="checkbox"/> Water Skiing	5. <input type="checkbox"/> Poisonous Plants/Insects (poison ivy/bee stings)	6. <input type="checkbox"/> Skating <input type="checkbox"/> Roller <input type="checkbox"/> Ice 7. <input type="checkbox"/> Illness/Sickness 8. <input type="checkbox"/> Other Accident
Overnight events	Was this an overnight event? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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