

**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 3  Cadette 6  Nonmember Child 9  Seasonal Staff  
 1  Brownie 4  Senior 7  Nonmember Adult 51  Ambassador  
 2  Junior 5  Adult Member 8  Staff

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
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