

# Volunteer Missionary Travel Insurance

## *Administrative Information*

Thank you for enrolling in our Volunteer Missionary Travel Insurance.

You will find attached, information regarding:

1. Summary of Coverages
2. Summary of Assistance Services
3. Enrollment Form
4. Claims Forms

Please advise if you need additional supplies

### **Adams & Associates**

**I N T E R N A T I O N A L**

PO Box 5845

Columbia, SC 29250-5845

Tel: (803) 758-1400 Fax: (803) 252-1988

E-Mail: [aai@aaintl.com](mailto:aai@aaintl.com) Internet: <http://www.aaintl.com>

### **Adams & Associates**

**I N T E R N A T I O N A L**

# Volunteer Missionary Travel Insurance

Due to numerous inquiries we have had from our clients, Adams & Associates International has developed a package of insurance benefits specifically designed for Volunteers.

## Summary of Coverages

Accidental Death & Dismemberment .....	\$100,000.00/Person
Disability Income Benefit for Permanent Total Disability	
For Accident 100 Month Benefit.....	\$1,000.00/Month
For Sickness 50 Month Benefit	
3 Month Waiting Period.....	\$250.00/Month
Medical Expense \$100.00 Deductible .....	\$2,500.00
*OPTION to INCREASE LIMIT to .....	\$10,000.00
This additional \$7,500.00 applies to Non-USA & Canada Medical Expenses ONLY	
Emergency Medical Transportation .....	\$25,000.00
Repatriation of Mortal Remains.....	\$5,000.00
Medical Assistance (24 Hour Telephone Service)	
For Assistance with Worldwide Medical Emergencies .....	Included
Property (Baggage) Insurance	
\$100.00 Deductible .....	\$2,500.00
Aggregate Limit.....	\$2,000,000.00
<p><b>Please Note:</b> This brief summary is not an insurance policy, rather, it outlines some of the features of this coverage. For specific details, please consult the Master Policy.</p> <p><b>Also Note:</b> This is not a major medical policy. Major Medical Coverage is available for individuals and groups on Short-Term and Long-Term Volunteer missionary assignments. If this is a need specific to your group, please contact us for details. contact us for details.</p>	

## Notes

1. The Aggregate Limit of \$2,000,000 provides the full \$100,000 AD&D coverage for up to 20 persons in a common accident. Higher limits up to \$10,000,000 are available for groups of 20 or more persons together and is included automatically when the additional premium on the Enrollment for 21 persons or more in the same group is paid.
2. The Accidental Death & Dismemberment and Disability Income Benefits do not apply to persons age 70 or over.

## Rate

**\$2.00 per person per day with a medical limit of \$2,500 - or -**

**\*\$2.55 per person per day with Optional "Overseas Only" medical coverage.  
(The entire group must enroll under the same plan).**

## Enrollment Procedure

To secure coverage, complete the form entitled Enrollment, Volunteer Missionary Insurance and return this along with your check for the premium made payable to: Adams & Associates International. In computing the number of days, count the departure day as well as the day of return.

**If coverage is being secured for a group, the group would be responsible for requiring all Volunteers to carry this insurance. In the event the entire group is not travelling on the same dates, please attach a separate sheet grouping the Volunteers by the dates they are traveling.**

# American International Group (AIG ASSIST)

## *Provided For Volunteer Missionaries*

*Adams & Associates International's plan designed for Volunteer Missionaries provides comprehensive travel assistance while traveling and serving overseas, by simply calling the telephone numbers provided.*

*These insurance benefits cover Volunteers Missionaries, who are covered by accidental death and dismemberment insurance, while in transit and overseas.*

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## Medical Assistance

**Medical Assistance can help the travelers get medical attention when someone suddenly becomes ill or is in an accident by:**

- locating medical facilities, including physicians, hospitals, or dentists
- verifying insurance coverage
- making arrangements with providers of medical care to avoid cash deposit, where possible, prior to obtaining treatment
- communicating with family members, personal physicians, and employers back home on the patient's condition
- assisting family or friends who are traveling with the patient

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## Emergency Medical Evacuation

**Emergency Medical Evacuation will make proper medical care available from anywhere:**

Medical Advisers - are always on hand to consult with attending physicians to make sure patients are receiving the correct medical care. But, sometimes more sophisticated treatment is warranted - treatment which may require evacuation to better medical facilities.

If deemed medically necessary, arrangements will be made for land and air transportation, including passage on either a commercial or chartered air ambulance, with in-flight physicians, paramedics or nurses and in-flight equipment and supplies. All family arrangements and immigration and customs details will also be handled.

Travel expenses associated with medical evacuation will be covered up to \$25,000.00 under this program.

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## Repatriation

Arrangements for repatriation of the remains of a deceased person will be made and up to \$5,000.00 of the expense will be covered by this program. (Some countries forbid the shipping of the deceased.)

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## Legal Assistance

Legal Assistance provides a ready resource for travelers helping to find English-speaking attorneys for persons in danger of being arrested as the result of any non-criminal action, or needing to replace lost or stolen documents, such as passports, or personal items, such as luggage.

*To use these services, contact American International Group (AIG ASSIST) and identify that you are with **Miscellaneous Volunteers, ID #9021798**.*

### **Call Houston, Texas:**

**24 Hour Service**  
1-800-626-2427

or

**Call Collect**  
713-267-2525

# Volunteer Missionary Travel Insurance

## Enrollment

Please make photocopies of this form for use on future mission trips.

Check One:  
 Group Leader  Travel Agent  Individual

### Please Print

Name:			
Signature:		Date:	
Address:			
City:		State:	Zip:
Phone:	Fax:		E-Mail:
Sponsoring Organization or Other Group:			
Master Policy Number:	<b>Miscellaneous Volunteers 9021798</b>		
Destination:	City:		Country:
Expected Date of Departure from Home:			
Expected Date of Arrival Back Home:			

Please note, this is not a major medical policy. Major Medical Coverage is available for individuals and groups on short-term and long-term volunteer missionary assignments. If this is a need specific to your group, please contact us for details.

### Premium Computation

Standard:	_____	X	_____	=	_____	X	2.00	=	_____
	Number of Persons		Number of Days		Person/Days				Premium
W/Optional:	_____	X	_____	=	_____	X	2.55	=	_____
	Number of Persons		Number of Days		Person/Days				Premium
<b>WHOLE GROUP MUST SELECT THE SAME PLAN</b>									
<b>Additional Charge of \$2.50 Per Person for Groups of 21 Persons or More ONLY.</b>									
21 Persons or More:	_____	X	2.50	=	_____				
	Number of Persons				Premium				
THIS IS A ONE TIME CHARGE									

### List of Persons

Name	Date of Birth	Beneficiary
1.		
2.		
3.		

If several persons are participating in a single project, but for different dates of service, please list these persons showing their dates separately, married couples traveling together should list both husband and wife. Travel agents or Group Leaders may attach roster in lieu of completing this list.

Mail or Fax to:

**Adams & Associates**  
**INTERNATIONAL**

PO Box 5845  
 Columbia, SC 29250-5845  
 Tel: (803) 758-1400 Fax: (803) 252-1988 E-Mail: aai@aaintl.com

**\*IMPORTANT\***

Please Sign At  
 "BY:"  
 On Reverse

**AIG Life Insurance Company Trust**  
**PARTICIPATION AGREEMENT**

For Policy Number 902-1798

THIS AGREEMENT, made and entered into as of the \_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, by and between Crestar Bank and \_\_\_\_\_.

**RECITALS**

1. Crestar Bank has been appointed and is acting as the Trustee under an Agreement of Trust dated January 1, 1986, titled the AIG Insurance Company Trust (the "Agreement of Trust"), by and between AIG Life Insurance Company and Crestar Bank, hereinafter with any other trustee or trustees serving under the Agreement of Trust referred to as the "Trustee"). The purpose of the Agreement of Trust is to afford group insurance benefits to qualifying persons, members, customers or employees of certain organizations.

2. EFCM (hereinafter, with any successor or successors thereto, referred to as the "Participant") desires to afford to qualifying insureds group insurance benefits of the sort available under the Agreement of Trust.

NOW, THEREFORE, in consideration of the mutual promises herein contained, the Trustee and the Participant hereby agree as follows:

1. Subject to approval of the insurance company or companies providing the group insurance pursuant to which insurance benefits shall be provided (the "Insurance Policies") for any insureds of the Participant, the Trustee agrees to permit the Participant to become a Participant under the Agreement of Trust.

2. The Participant agrees to be bound by: (a) the provisions of the Agreement of Trust, and (b) each and every provision of the Insurance Policies (and all riders and amendments thereto). The definitions contained in the Agreement of Trust shall apply in the construction and interpretation of this Participation Agreement.

3. In particular, but without the generality of the foregoing, the Participant agrees promptly to furnish to the Trustee and the insurance company or, if requested by the Administrator under the Agreement of Trust to do so, to the Administrator, all records and other information required by the insurance company to administer properly the Insurance Policies and to permit the Trustee, the insurance company and/or the Administrator, whenever and as often as the Trustee, the insurance company and/or the Administrator may reasonably require, to inspect the records of the Participant bearing on the Insurance Policies.

4. The Participant hereby appoints the Administrator (if any) acting under the Agreement of Trust to represent the Participant in all dealings with the Trustee having to do with the insurance fund, including, by way of example and not of limitation of the foregoing, such matters as instructions to the Trustee, the resignation or dismissal of the Trustee and the appointment of a successor or successors, amendment of the Agreement of Trust, the fixing and adjustment of the Trustee's fee and all other matters pertaining to the construction of the Agreement of Trust, its effect and the administration of the insurance fund.

5. In the event that the Participant shall withdraw as a Participant under the Agreement of Trust in accordance with the provisions thereof, the Participant agrees that it shall relinquish any and all claims the Participant may have on the date on which such withdrawal becomes effective, or which thereafter may accrue, to any portion of the insurance fund.

6. The Trustee shall make available at its principal place of business and during normal business hours, upon reasonable notice to the Participant or any one or more of the qualifying persons, members, customers or employees of the Participant an executed original counterpart of the Agreement of Trust and all amendments thereto which shall at the time be in force and effect.

7. The Participant shall pay, when due, the cost of all group insurance applicable to the Participant's qualifying persons, members, customers or employees by means of a check or checks payable to the Trustee or its designee. Payment in any other manner shall be at the risk of the Participant.

IN WITNESS WHEREOF, on the day and year first above written, the parties hereto have caused these presents to be executed by their respective officers thereunto duly authorized.

Accepted on behalf of Trustee:

PARTICIPANT: \_\_\_\_\_

ADAMS & ASSOCIATES INTERNATIONAL

EVANGELICAL FREE CHURCH MISSION

By: \_\_\_\_\_  
Administrator

\*By: \_\_\_\_\_

**Property Claim Report**

*Provided For Volunteer Missionaries*

Claim Number	Policy Number
	7312-2234

Insured: \_\_\_\_\_

**Present Address:** (Number and Street) \_\_\_\_\_ (City) \_\_\_\_\_ (Zip) \_\_\_\_\_ (Country) \_\_\_\_\_

**Mailing Address:** (Number and Street) \_\_\_\_\_ (City) \_\_\_\_\_ (Zip) \_\_\_\_\_ (Country) \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Claim is hereby presented to: \_\_\_\_\_  
Name of Insurance Company shown on policy \_\_\_\_\_  
For \$ \_\_\_\_\_ Loss, \$ \_\_\_\_\_ Property Damage, Total \$ \_\_\_\_\_ Caused by \_\_\_\_\_  
Which occurred at: \_\_\_\_\_  
(Location, including City and Country)  
On \_\_\_\_\_, 19 \_\_\_\_\_, At About \_\_\_\_\_ M. In the following manner:

Was property in custody of Steamship Company, Railroad Company, Airline or Other Carriers? Yes No  
A. If Yes, Give Name and Identity: \_\_\_\_\_  
(Identify Voyage, Railroad, or Flight Number)  
B. Was Property Shipped under a Bill of Lading or Similar Consignment Document?  
(If Yes, attach a Copy of Bill of Lading or Consignment Document) Yes No  
C. Has a Formal Claim been filed against Carrier or Shipper? Yes No  
D. If Yes, Furnish Date and Place: \_\_\_\_\_  
E. If No Report made against Carrier or Shipper, Please explain the Reason fully: Yes No

Who Packed Baggage?: \_\_\_\_\_  
(Name and Address)  
Who Sealed it?: \_\_\_\_\_ How was it Sealed? \_\_\_\_\_  
(Name and Address)

**For Burglary Losses**

Were there Visible Marks of Forcible Entry to the Premises? Yes No  
To any Safe or Vault Insured?  
If Answer is "Yes", describe these Marks in detail: \_\_\_\_\_ Yes No

**Police Report**

1. Where Made: \_\_\_\_\_ Date: \_\_\_\_\_  
(Address, or Policy Precinct Number) (City) (Country)  
2. What Police Action was taken? \_\_\_\_\_

**For Theft or Robbery**

Name and Addresses of Custodian, Guards, and Witnesses

Name	Address	Custodian, Guard, or Witness

THERE IS NO OTHER INSURANCE APPLICABLE TO THIS LOSS EXCEPT AS STATED HEREIN.

Name of Insurance Company	Policy Period	Coverage or Bond Form	Amount of Insurance
	From To		
	From To		

No other loss caused by perils covered under this policy has been suffered during the last five years except as follows:  
 (Give Dates of Previous Losses and, if Insured, Name of Insuring Company.)

**Schedule of Loss**

**\*ON ANY ITEM OVER \$200.00, PLEASE PROVIDE PROOF OF VALUE**

Description of Articles	Name and Address of Owner	From Whom Acquired (Name and Address)	Date Acquired (Attach Bills)	Current Replacement Cost*	Depreciation in Value Due to old Style, Usage, or Shop Wear	Amount Claimed
<b>*Including Local Duty and Taxes</b>				<b>Totals</b>		

Describe any Damage to Property caused by this occurrence; and attach written Estimate or Repair Bills.

Please furnish us with the following:

Name of your Group: \_\_\_\_\_ Group Leader and/or Travel Agency: \_\_\_\_\_  
 City and Country Visited: \_\_\_\_\_ Dates of Mission: \_\_\_\_\_

It is understood and agreed that the furnishing of this form to the insured, or its preparation by any representative of the company, or the acceptance or retention of the proof thereafter by the company shall not constitute a waiver of any of the conditions of this policy.

Dated at \_\_\_\_\_ (City, State and/or Country) \_\_\_\_\_ (Signature of Insured)

This \_\_\_\_\_ Day of \_\_\_\_\_ 19 \_\_\_\_\_

Witnessed by \_\_\_\_\_

Subscribed and sworn to before me this \_\_\_\_\_ Day of \_\_\_\_\_ 19 \_\_\_\_\_

At \_\_\_\_\_ Notary Public \_\_\_\_\_

(If Being Executed Outside U.S.A. Notary Public Affirmation IS NOT Required)

**Please return this completed form to:**

**Adams & Associates**

**I N T E R N A T I O N A L**

PO Box 5845

Columbia, SC 29250-5845

Tel: (803) 758-1400 Fax: (803) 252-1988

E-Mail: aai@aaintl.com Internet: http://www.aaintl.com

# Adams & Associates INTERNATIONAL

## American International Companies PROOF OF LOSS

Please mail or fax to: **Adams & Associates  
INTERNATIONAL**  
P. O. Box 5845  
Columbia, SC 29250  
Tel: (803) 758-1400  
Fax: (803) 252-1988

**NAME OF GROUP: MISCELLANEOUS  
VOLUNTEERS**

**POLICY NUMBER: 9021798**

### SPECIAL RISK ACCIDENT AND SICKNESS CLAIM FORM

#### INSTRUCTIONS:

- 1) You must have SECTION A fully completed by a designated official of the Policyholder.
- 2) SECTION B is to be completed, signed and dated by the claimant or parent/guardian of claimant, if claimant is a minor.
- 3) If claimant is treated in the hospital, please attach an itemized hospital bill.
- 4) If claimant is treated by a doctor, have the doctor complete the Physician's Statement or attach an itemized bill.
- 5) Attach itemized bills for all medical expenses being claimed including the claimants name, condition being treated (diagnosis), description of services, date of service(s) and the charge made for each service.
- 6) Please mail completed form and bills to the above address.

The furnishing of this form, or its acceptance by the Company, must not be construed as an admission of any liability on the Company, nor a waiver of any of the conditions of the insurance contract.

Any person who knowingly and/or with intent to injure, defraud, or deceive an insurance company or other person files a statement of claim containing false, incomplete or misleading information, may be guilty of insurance fraud and subject to criminal and substantial civil penalties.

#### SECTION A

LOCATION OF GROUP POLICYHOLDER (EMPLOYER, SENDING ORGANIZATION OR PROJECT SPONSOR)

CLAIMANT'S FULL NAME	SOCIAL SECURITY NO. (IF AVAILABLE)	DATE OF BIRTH	NAME OF SUPERVISOR
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DATE COVERAGE BEGAN	DATE COVERAGE WILL END/HAS ENDED
---------------------	----------------------------------

NATURE OF INJURY OR ILLNESS (DESCRIBE FULLY, INCLUDING WHICH PART OF BODY WAS INJURED):

DESCRIBE HOW, WHEN AND WHERE ACCIDENT OCCURRED (DATE AND TIME):

NAME OF PROJECT AND COUNTRY VISITED:	DID ACCIDENT OCCUR: A. WHILE CLAIMANT WAS SUPERVISED [ ] YES [ ] NO B. DURING SPONSORED ACTIVITY [ ] YES [ ] NO C. DURING PROGRAMMED HOURS [ ] YES [ ] NO D. WHILE TRAVELING TO OR FROM REGULARLY SCHEDULED ACTIVITY IN A SUPERVISED GROUP [ ] YES [ ] NO
PROJECT NUMBER:	
GROUP LEADER OR TRAVEL AGENCY:	
DATES OF TRIP:	

DATE LAST WORKED	DATE RETURNED TO WORK	WEEKLY EARNINGS
------------------	-----------------------	-----------------

POLICYHOLDER REPRESENTATIVE (PLEASE PRINT OR TYPE) TITLE	DAYTIME TELEPHONE NUMBER ( )
--	------------------------------

SIGNATURE OF POLICYHOLDER REPRESENTATIVE	DATE	E-MAIL:
--	------	---------

#### SECTION B

NAME OF CLAIMANT (PARENT OR GUARDIAN IF A MINOR)	DAYTIME TELEPHONE NO. ( )	E-MAIL:
--	---------------------------	---------

ADDRESS OF CLAIMANT (PARENT OR GUARDIAN IF A MINOR)

OTHER HEALTH INSURANCE COVERAGE (ENTER NAME OF INSURED, NAME AND ADDRESS OF INSURANCE COMPANY, NAME OF EMPLOYER AND POLICY NUMBER)  
YES \_\_\_\_\_ NO \_\_\_\_\_

**I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.**

SIGNATURE (CLAIMANT OR PARENT, IF CLAIMANT IS MINOR) DATE

#### AUTHORIZATION

I, the undersigned authorize any hospital or other medical-care institution, physician or other medical professional, pharmacy, insurance support organization, governmental agency, group policyholder, insurance company, association, employer or benefit plan administrator to furnish to the Insurance Company named above or its representatives, any and all information with respect to any injury or sickness suffered by, the medical history of, or any consultation, prescription or treatment provided to, the person whose death, injury, sickness or loss is the basis of claim and copies of all of that person's hospital or medical records, including information relating to mental illness and use of drugs and alcohol, to determine eligibility for benefit payments under the Policy Number identified above. I authorize the group policyholder, employer or benefit plan administrator to provide the Insurance Company and above with financial and employment-related information. I understand that this authorization is valid for the term of coverage of the Policy identified above and that a copy of this authorization shall be considered as valid as the original. I understand that I or my authorized representative may request a copy of this authorization.

CLAIMANT OR AUTHORIZED PERSON'S SIGNATURE DATE

**Section B**

**HEALTH INSURANCE CLAIM FORM**

**CLAIMANT INFORMATION**

1. MEDICARE OTHER [ ] (Medicare#) [ ] (ID)		MEDICAID [ ] (Medicaid) [ ] (Sponsor's SSN) [ ] (VA File #) [ ] (SSN or ID) [ ] (SSN)		CHAMPUS CHAMPVA GROUP HEALTH PLAN		FECA BLK LUNG		1a. INSURED'S I.D. NUMBER													
2. PATIENT'S NAME (First Name, Middle Initial, Last Name)				3. PATIENT'S DATE OF BIRTH MM / DD / YY		SEX M [ ] F [ ]		4. INSURED'S NAME (First Name, Middle Init., Last Name)													
5. PATIENT'S ADDRESS (No. Street) CITY STATE ZIP CODE TELEPHONE NO. ( )				6. PATIENT'S RELATIONSHIP TO INSURED SELF [ ] SPOUSE [ ] CHILD [ ] OTHER [ ] (SPECIFY)				7. INSURED'S ADDRESS (No. Street) CITY STATE ZIP CODE TELEPHONE NO. ( )													
8. PATIENT'S STATUS Single [ ] Married [ ] Other [ ] Employed [ ] Full Time Student [ ] Part-Time Student [ ]				9. OTHER INSURED'S NAME				10. IS PATIENT'S CONDITION RELATED TO:													
A. OTHER INSURED'S POLICY OR GROUP NO.				A. PATIENT'S EMPLOYMENT? YES [ ] NO [ ]				3. PATIENT'S DATE OF BIRTH MM / DD / YY SEX M [ ] F [ ]													
B. OTHER INSURED'S DATE OF BIRTH MM / DD / YY SEX M [ ] F [ ]				B. AN AUTO ACCIDENT? YES [ ] NO [ ]				B. EMPLOYER'S NAME OR SCHOOL NAME													
C. EMPLOYER'S NAME OR SCHOOL NAME				C. OTHER ACCIDENT? YES [ ] NO [ ]				C. INSURANCE PLAN NAME OR PROGRAM AKA													
D. INSURANCE PLAN NAME OR PROGRAM NAME PLAN?				D. RESERVED FOR LOCAL USE				D. IS THERE ANOTHER HEALTH BENEFIT YES [ ] NO [ ] If yes, return to & complete item 9A-D													
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. Signature _____ Date _____						13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to undersigned physician or supplier for service described below. Signature _____ Date _____															
14. DATE OF CURRENT: ILLNESS (First symptom) OR Patient Unable To Work in Current Occupation MM / DD / YY INJURY (Accident OR PREGNANCY (LMP))						15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM / DD / YY FROM: MM / DD / YY TO: MM / DD / YY															
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE						17a. I.D. NUMBER OF REFERRING PHYSICIAN															
19. RESERVED FOR LOCAL USE						18. Hospitalization Dates Related to Current Services MM / DD / YY MM / DD / YY FROM: / / TO: / /															
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, (RELATE ITEMS 1, 2, 3, OR 4 TO ITEM 24E B LINE)						20. OUTSIDE LAB? \$CHARGES YES [ ] NO [ ]															
1. _____ 3. _____						22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.															
2. _____ 4. _____						23. PRIOR AUTHORIZATION NUMBER															
24A		B		C		D		E		F		G		H		I		J		K	
DATE(S) OF SERVICE FROM MM/DD/YY TO MM/DD/YY		Place of Service		Type of Service		PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		DIAGNOSIS CODE		CHARGES		DAYS OR UNITS		DPSDT Family Plan		EMG		COB		RESERVED FOR LOCAL USE	
25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]				26. PATIENT'S ACCOUNT NO.				27. ACCEPT ASSIGNMENT? [ ] YES [ ] NO				28. TOTAL CHARGE \$		29. AMOUNT PAID \$		30. BALANCE DUE \$					
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements apply to this bill and are made a part thereof) SIGNED _____ DATE _____						32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)						33. PHYSICIAN'S OR SUPPLIERS NAME, ADDRESS, ZIP CODE & TELEPHONE # PIN# _____ IGRP# _____									

PLACE OF SERVICE CODES  
 1-(H) - INPATIENT HOSPITAL      4-(H)-PATIENT'S HOME      7-(NH)-NURSING HOME      O-(OL)-OTHER LOCATIONS  
 2-(OH)-OUTPATIENT HOSPITAL    5- -DAYCARE FACILITY (PSY)    8-(SNF)-SKILLED NURSING FACILITY    A-(IL)-INDEPENDENT LABORATORY  
 3-(O)-DOCTOR'S OFFICE          6- -NIGHT CARE FACILITY (PSY)    9- -AMBULANCE                            B- -OTHER

# Volunteer Missionary Travel Insurance

**Please Print**

*Master Questionnaire*

Name of Group:				
Contact Person:				
Address:				
City:	State:	Zip:		
Phone:	Fax:	E-Mail:		
Sponsoring Organization or Other Group:				
Denominational affiliation, if any:				
Association affiliation, if any:	EFMA	IFMA	DOM	FOM
	CWC	AIMS	OTHER	
Nature of the mission activities you sponsor (preaching, medical, construction, media, etc.):				
Area or countries in which your personnel serve:				
Average number of missionaries serving overseas:				
Average length of stay:				
<b>Please attach any brochures or other literature you may have available to help us understand your ministry and its operations.</b>				
<b>In signing this application, I understand:</b>				
1. No insurance is in effect until a policy or confirmation of coverage is issued.				
2. The sending agency is under no obligation to purchase insurance.				
3. <b>This is not a major medical policy.</b> Major medical coverage is available for individuals and groups on Short-Term and Long-Term Volunteer missionary assignments. If this is a need specific to your group, please contact us for details.				
Signature: _____				
Title: _____		Date: _____		

**Please return the completed questionnaire to:**

**Mail or Fax to:**

**Adams & Associates**  
**I N T E R N A T I O N A L**

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