s.a. van dyk
incorporated

Insurance Consultants and General Agents

1010 JORIE BOULEVARD
P.O. BOX 4806
OAK BROOK, ILLINOIS 60522-4806
(630) 990-7300
(800) 323-7326
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E-mail: savinsur@aol.com
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World - Wide Coverage

World - Wide Service

Dear Parent or Guardian:

We are truly sorry that your son required medical attention while in attendance at Boys State. Every effort is made to avoid accidents and sickness, but the unforeseen happens.

In an effort to relieve the financial difficulties that, unfortunately, often accompany such occurrences, Boys State has made available to you a group accident and sickness insurance policy issued by Sentry Insurance. The policy provides reimbursement of expenses of up to $2,000.00 for sickness and $10,000.00 for accidents, but is ***excess*** coverage to any other valid and collectible group insurance plans you may have. (This exclusion does not apply to individual accident and sickness policies.)

Enclosed you will find a Sentry Claim Form. The claim form should already have the top half of the front page completed by the Activity Supervisor at Boys State and the back side completed by the attending physician.

Should you wish to eventually apply for benefits under the Boys State policy, we ask that you first submit the bill to your group insurance carrier. After their benefits have been determined, please send to S. A. Van Dyk, Inc., for our consideration a copy of their payment or rejection notice, the original bill, and the enclosed Sentry Claim Form with the "Parent Statement-other Insurance" completed. If no other insurance is involved simply indicate this. We can then expedite your claim and provide you with prompt service.

Again, we are sorry for this inconvenience to your family. We will do our part to bring about a prompt and satisfactory settlement.

Sincerely,

S. A. VAN DYK, INC.

Maggie Van Dyk

Margaret E. Van Dyk
President

AMERICAN LEGION
BOYS-GIRLS STATE

DATE RECEIVED:

SENTRY INSURANCE
Stevens Point, Wisconsin

MAIL TO: S.A. VAN DYK INC., P.O. BOX 4806, OAK BROOK, IL 60522

TO BE COMPLETED BY ACTIVITY SUPERVISOR

NAME OF ORGANIZATION		CERTIFICATE NUMBER:
ADDRESS (No., Street, City, State)		
PLACE OF ACCIDENT:	DATE: / /	TIME:
DESCRIPTION OF ACCIDENT AND NATURE OF INJURIES:		
NAME OF SUPERVISOR OF ACTIVITY:	WAS SUPERVISOR A WITNESS? ☐Yes ☐No	ARE THE ABOVE STATEMENTS TRUE AND CORRECT TO THE BEST OF YOUR KNOWLEDGE? ☐Yes ☐No
ADDRESS:		TELEPHONE NUMBER:
SUPERVISOR'S SIGNATURE:	TITLE:	DATE: / /
NAME OF CLAIMANT:		DATE OF BIRTH:
HOME ADDRESS:		

TO BE COMPLETED BY PARENT OR RESPONSIBLE PARTY

PARENT OR RESPONSIBLE PARTY STATEMENT – OTHER INSURANCE

IMPORTANT: Your claim cannot be processed unless this section is fully completed.

The American Legion Boys-Girls State is a low cost insurance program that provides benefits for medical expenses not covered by other family insurance. In order for us to determine benefits, you must first file a claim with your own family insurance company. The Legion insurance policy will pay eligible expenses not paid by your own coverage. In order to continue this plan, YOUR COOPERATION is necessary. Please answer all questions. Failure to provide complete claim information will prolong payment of allowable benefits.

1. Parent's Name _____ Home Phone Number _____
   Address _____
   (Street or Route) (City) (State) (Zip)
2. Father's Occupation _____
   Employer _____
   Name Address Phone No.
   Mother's Occupation _____
   Employer _____
   Name Address Phone No.
3. Do you have coverage under another insurance plan? ☐Yes ☐No
4. List all family medical/dental insurance policies _____
   (Attach sheet if more space needed)
   Name of Insurance Company _____ ☐Group ☐Individual Policy No.(s) _____
   Address _____
   (Street) (City) (State) (Zip)
   To whom (Employer, Union, etc.) was that policy issued? _____

I hereby authorize any insurance company, hospital, physician, or other person who has attended or examined the claimant to disclose when requested to do so by Sentry Insurance a Mutual Company, or its representative, any and all information with respect to any injury, policy coverages, medical history, consultation, prescription or treatment and copies of all hospital or medical records. A photostatic copy of this authorization shall be considered as effective and valid as the original.

I authorize release of any information necessary to process this claim, including any information received from employers.

If other insurance is involved, please attach a copy of their payment or denial notice to this claim. Processing of your claim will begin when we receive this information.

_____ _____
Date Signature of Parent or Guardian

AFFIDAVIT

SIGN:

I verify that the above statement on other insurance is accurate and complete. I understand that the intentional furnishing of incorrect information via the U.S. Mail may be fraudulent and violate federal laws. I agree that if it is determined at a later date that there are other insurance benefits collectible on this claim I will reimburse Sentry Insurance a Mutual Company to the extent of any amount collectible.

Parent or Guardian _____ Date _____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the undersigned Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his services described or attached but not to exceed the reasonable and customary charge for those services.

SIGNED (INSURED PERSON)

DATE / /