CIVIL AIR PATROL DEATH BENEFIT/MEDICAL EXPENSE CLAIM FORM
(SENIOR MEMBERS AND CADETS)

Name of Injured or Deceased Member _____ Senior ☐ Cadet ☐
Last First Middle Initial
CAP Charter No: _____ CAPID: _____ Date of Birth _____
Day Month Year

Address: _____
Street City State Zip

PART 1: ACCIDENT INFORMATION

When and where did this accident occur: _____
Date City State

Give a brief description of the accident: _____

_____

_____

Was the injured person involved in an official activity? _____

Person who authorized CAP Activity:

Name and Grade: _____ Position: _____

Address: _____ Phone No. _____
Street City State

NOTE: ATTACH DEATH CERTIFICATE IF APPLICABLE.

PART II-. FAMILY INFORMATION (Do Not Complete in Death Cases)

Name of Employer, *(Parents of Cadets):* _____

Name of Employer, *(Parents of Cadets):* _____

PART III: OTHER INSURANCE INFORMATION (Do Not Complete in Death Cases)
Is there medical reimbursement coverage available from any insurance company or program e.g.

Champus: Yes ☐ No ☐

Name of Insurance Company: _____ Policy No: _____

Address: _____ _____
Street City State Zip Phone No.

Agent Name & Address: _____

Agent Telephone Number: _____

Have you filed a claim with another insurance company? _____

Are you covered by Workmen's Compensation from this accident? _____

PART IV: REIMBURSEMENT INFORMATION (Do Not Complete in Death Cases)

Total amount of medical expenses incurred for the accident (attach bills) _____

Reimbursement from other insurance (attach claim information & copy of payment) _____

Indicate amount of other insurance deductible _____

Indicate amount of other insurance co-insurance (attach copy of payment) _____

Indicate to whom CAP benefit check should be payable: _____

Will there be additional amounts claimed from CAP? Yes ☐ No ☐

IMPORTANT: To avoid delay, please sign Authorization below:
I hereby authorize any Insurance Company, Organization, Employer, Hospital, Physician, Surgeon or Pharmacist to release any information requested with respect to this claim and the attached bills.

I certify that the information furnished in this report is true and correct to the best of my knowledge.

Date _____ Signed Member: _____

Charter No: _____ CAPID: _____

Parent/Guardian/Next of kin: _____
(if member is a minor)

Address: _____
Street City State Zip

Telephone No: _____ Home

_____ Work

ALL BILLS TO BE CONSIDERED FOR REIMBURSEMENT MUST BE ATTACHED TO THIS STATEMENT.

SEND TO: NHQ /GC
BLDG 714, 105 S. HANSELL ST.
MAXWELL AFB AL 36112-6332

NOTE: Benefits are payable only for accidental injuries or deaths incurred on official CAP activities. Medical benefits are excess to existing coverage and will be made to the member or family only. (See CAPR 900-5)