



Explicación seguros anuales UICASDE-JAE

La Unión Adventista española tiene contratado una póliza anual con la compañía adventista de seguros **Adventist Risk Management, Inc.** El seguro tiene carácter **anual** y tiene una vigencia desde el 1 de abril de cada año en curso, al 31 de marzo del año siguiente.

El Consejo de Unión votó en 2015 que la adhesión al seguro sea de obligado cumplimiento para todas las iglesias/clubes de jóvenes/exploradores, para poder adecuarse a la legislación al respecto, que obliga a la contratación de un seguro para la realización de actividades de tiempo libre. Cada año, antes de la renovación, se solicitará a las iglesias el número de jóvenes/exploradores que asisten regularmente para poder actualizar las cifras y realizar el cargo correspondiente.

La póliza contratada anualmente es sufragada por todas las iglesias en base al número de jóvenes/exploradores que declaran como asistentes. De forma que se realiza una **única póliza** para toda España, con carácter no-nominal.

Esto permite que la cobertura sea para todas las actividades oficiales de la iglesia (nacionales, eventos de zona o locales) realizadas con aprobación de un Consejo de Iglesia.

COBERTURAS:

La póliza es de Responsabilidad Civil y de Accidentes.

RESPONSABILIDAD CIVIL	1.000.000 Dólares
MUERTE ACCIDENTAL O INVALIDEZ	Hasta 20.000 Dólares
EVACUACIÓN MÉDICA DE EMERGENCIA	100% Cubierta
EVACUACIÓN DE RESTOS	100% Cubierta
FRANQUICIA	Sin franquicia
ACTIVIDADES DE ALTO RIESGO (Extensión)	Escalada, Tirolina, Rappel, Vía Ferrata, Esquí acuático, etc. (CUBIERTAS)

La póliza de **Responsabilidad Civil** cubre responsabilidad civil general imputable a los responsables y monitores, como consecuencia de daños corporales y materiales causados a terceros por ellos mismos o por las personas de que deban responder.

Garantiza la responsabilidad civil por daños corporales de los cuales puedan ser víctimas los propios participantes derivados de la utilización de los locales, las instalaciones y en las actividades organizadas o controladas por la Iglesia.

También cubre a los monitores/responsables que en el ejercicio de sus funciones cometieran alguna **negligencia** (aun cuando no estén titulados). Esta póliza no cubre posibles responsabilidades penales (si las hubiere).

El **seguro de Accidentes** en España, al disponer de atención sanitaria universal, es un complemento de la tarjeta de la Seguridad Social o Mutua del menor y del monitor. En caso de accidente, primero debe utilizarse dicha tarjeta, ya que el trámite es más sencillo: sólo es necesario mostrar una fotocopia de la tarjeta o dar simplemente el número de afiliación a la Seguridad Social del accidentado o accidentados al hospital, ya sea telefónicamente o en el mismo centro sanitario.

La póliza cubre los accidentes que puedan producirse mientras los asegurados estén realizando actividades organizadas por la entidad, incluyendo el riesgo "in itinere" (durante el viaje a la actividad). La póliza tiene las exclusiones habituales: guerras, terremotos, enfermedades, embriaguez, suicidio o tentativa, peleas, apuestas, exposición voluntaria a peligros inútiles, uso de aeronaves, etc.

Importante: Una vez contratado este seguro (ya está vigente) **no será necesario** informar a la Unión Adventista cada vez que se vayan a realizar actividades, excursiones, etc. Basta que la actividad haya sido aprobada oficialmente por el consejo de iglesia.

PROCEDIMIENTO EN CASO DE ACCIDENTE:

Prestar inmediata asistencia al afectado o afectados. Presentar fotocopia de la tarjeta de la Seguridad Social o Mutua al centro médico donde atiendan al accidentado o accidentados, o facilitar con posterioridad el número de afiliación. En este caso no hay que realizar **ninguna otra acción**.

Sólo en el caso de que la persona afectada **no disponga** de tarjeta de afiliación familiar a la Seguridad Social o Mutua y debáis utilizar la póliza de seguros, es importante lo siguiente:

- Recoger en el centro hospitalario las **facturas** o documentos de cargo correspondientes.
- Recoger el **informe** médico/parte del hospital.
- Una vez en casa, rellenar el **parte de accidente** "Accident&Sickness Medical Claim Form" (adjunto).
- Enviar a la Unión Adventista, una **copia de todos los documentos** (factura, informe médico y parte de accidente). La Unión Adventista terminará de gestionar el parte directamente con Adventist Risk Management, Inc. para proceder al reembolso de las cantidades abonadas.

El proveedor final del seguro es: **EUROP ASSIST**

Datos de la póliza:

INSURANCE & TRAVEL ASSIST ID CARD		For emergency evacuation and travel assistance
Services:		If in the United States or Canada, call (1-888) 927-5353
Travel Assistance	Security Assistance	To call collect from anywhere else in the world, contact an International Operator to place your call to : (01-240) 330-1570
VIP Concierge Services	Travel Medical Assistance	To report claims or to verify eligibility
Identity Theft		Adventist Risk Management Customer Care & Operations 12501 Old Columbia Pike Silver Spring MD 20904 1-888-951-4276 claims@adventistrisk.org
Insured Name: Spanish Union		Insurance Provider: ACE
Coverage Dates: 4/1/2015, 4/1/2016		Assistance Provider: Europ Assist
Insurance Type: International Pathfinders		
Policy Number: PTP N04822699		

Accident & Sickness Medical Claim Form

Please mail completed Claim Form with itemized bills and receipts to:

(To expedite your claim, please fax it with readable receipts.)

Claims & Legal Services
 Adventist Risk Management
 12501 Old Columbia Pike
 Silver Spring, MD 20904

Phone: (301) 680-6870
Fax: (301) 680-6878
E-mail: claims@adventistrisk.org

Please complete Sections A, B and C. Complete Section D if the claim is for a dependent, other coverage is in effect, or if the claim is accident related. Complete a separate Claim Form for each individual. Attach bills and/ or receipts and return to the address listed above. Please note that you may scan and email or fax claims.

SECTION A INSURED / PATIENT INFORMATION			
Name of Group		Policy Number	
Insured's Name		Insured's Date of Birth	
Patient's Name		Patient's Date of Birth	
Home Address			
Please provide telephone and facsimile numbers, with country and city codes.			
Home Phone Number	Work Phone Number	Fax Number	E-mail Address
Manager's Name	Work Phone Number	Fax Number	E-mail Address

SECTION B TRAVEL INFORMATION Please complete this section	
My Business location is in (country of employment)	
I / we left the above country on (Day / Month / Year)	
I / we visited the following countries	
I / we are expected to return home on (Day / Month / Year)	
The purpose of my / our trip was	

SECTION C PAYMENT INFORMATION Please complete Option #1, #2 or #3	
<input type="checkbox"/> OPTION #1 - Payment to INSURED Please indicate where you wish the payment to be sent and in what currency. <input type="checkbox"/> Your home address as listed above <input type="checkbox"/> Direct deposit to your bank account	
Name on account:	Account #:
Bank Name:	Swift Code:
Bank Address:	Currency:
IBAN:	
<input type="checkbox"/> OPTION #2 - Payment to a Provider, e.g. hospital, physician Please complete Provider's name and address in Section E of this Claim Form	
<input type="checkbox"/> OPTION #3 - Payment to the Employer	
Employer's Name:	

Employer's Address: _____

Payment Authorization: I authorize payment directly to me, my employer or to the healthcare provider in Section E of this Claim Form.

INSURED'S SIGNATURE _____ DATE _____

Patient's Signature and Release (Parent or Guardian, if claim is for a minor), I certify, to the best of my knowledge, that this Claim Form does not contain any false, misleading, or incomplete information. I authorize the release of all records or other information which may be necessary to determine claim payment.

PATIENT'S SIGNATURE _____ DATE _____

SECTION D OTHER COVERAGE INFORMATION Complete only if the claim is for a dependent and/or other coverage is in effect or if the claim is accident or work related.	
Do you have any other insurance? If yes, please provide source of insurance. <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is this claim accident related? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is this claim worked related? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide documents relating to accident or work injury.
If claim is due to an accident, are you seeking reimbursement from another source? If yes, please provide source of insurance. <input type="checkbox"/> Yes <input type="checkbox"/> No	
Spouse's name	Spouse's insurance company
Spouse's employer and telephone #	
Dependent's date of birth	Is your dependent a full-time student? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide documentation of current academic registration.

SECTION E PHYSICIAN OR PROVIDER Please complete this section.			
Name of physician or provider of service			
Address			
Telephone #			
Diagnosis or nature of illness or injury			
Date of illness (first symptom) or injury		Date first consulted for this condition	
Hospital confinement dates: From _____ To _____		Date able to return to work	
Total disability dates: From _____ To _____		Partial disability dates: From _____ To _____	
Patient's account #		Amount paid	Balance due
Place of service		Diagnosis code and description	
Date of Service	Procedure code and description/ Predetermination of benefits	Charges	Total charges

AUTHORIZATION and ASSIGNMENT OF BENEFITS

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 policyholder, employer or benefit plan administrator to provide the Insurance Company named 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 agree that a photographic copy of this Authorization shall be a valid as the original.
- I understand that I or my authorized representative may request a copy of this authorization.
- I understand that I or my authorized representative may revoke this authorization at any time by providing the insurance company with written notification as to my intent to revoke.

Signature of Insured or Authorized Representative	Relationship, If Other Than Insured	Dated
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Address:

Fraud Warning: Certain states require specific state mandated fraud language to be included on all claims forms while other states use a generalized fraud stated. ACE USA Accident & Health has adopted the fraud warning language prescribed by the District of Columbia as its standard fraud statement. Unless otherwise noted below this statement shall be included on all claims forms, applications and enrollment forms.

District of Columbia Generic Warning:
It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

The following states have required us to use state specific language as follows:

California
For your protection California law requires the following to appear on this form:
Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado
It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages.

Florida
Any person who knowingly and with intent in injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

New York
Any person who knowingly and with 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 thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed \$5,000 and the stated value of the claim for each such violation.

Oklahoma
WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes ant claim for the process of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Pennsylvania
Any person who knowingly and with intent to defraud any insurance company or other person files a 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 subjects such person to criminal and civil penalties.

Maryland/Oregon
Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

Virginia
Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer submits an application or files a claim containing a false or deceptive statement may have violated state law.