

U.S. NAVAL SEA CADET CORPS U.S. NAVY LEAGUE CADET CORPS		<h1>ACCIDENT/ILLNESS REPORT</h1>		This form MUST be completed on all injuries/accidents/illnesses regardless if immediate medical care is sought/obtained.	
INSTRUCTIONS					
<p>1. Cadets or Officers enrolled or re-enrolled prior to 1 April, 2003, are covered under CIGNA Insurance policy as the <u>primary insurer</u> up to \$10,000 for accidents only. Please mail all bills to NSCC National HQ at 2300 Wilson Blvd., Arlington, VA 22201. The parent, or guardian must pay the first \$100.00 of ALL medical expenses to the hospital or physician.</p> <p>2. Cadets or Officers enrolled 1 April, 2003 or later are covered with Nationwide Insurance Company as a <u>secondary insurer</u>. Your personal family health insurer pays first. Any payments not covered by your personal insurer may be sent to Nationwide for consideration. Bills should be sent to Nationwide Life Insurance Co., Attn: Special Risk Health Claims, PO Box 2399, Columbus, OH 43216-2399 with a form supplied from NSCC NHQ. If you do not have accident/health insurance, the Nationwide Policy will cover up to \$25,000.00 accident and \$5,000.00 illness.</p>					
1. MEMBER INFORMATION					
1a. Last Name		1b. First Name		1c. MI	1d. Rank/Rate
1e. Social Security Number	1f. ID Expiration Date		1g. Date of Birth	1h. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	1i. Home Address
1j. City		1k. State	1l. Zip Code + 4	1m. Home Phone	
1n. Next of Kin Name			1o. Next of Kin Address & Phone (if different than above)		
2. UNIT INFORMATION					
2a. Unit Name					2b. Region
3. ACCIDENT/ILLNESS INFORMATION					
3a. Date of Occurrence		3b. Time of Occurrence		3c. Place of Occurrence	
3d. Description of Injury/Illness					
3e. Give a Brief Description of Group Activity Engaged in at Time of Accident or Illness.					
3f. Description of Accident/Illness (Describe the accident or illness in detail, including the events leading to and immediately following the occurrence. Add attachments if necessary.)					
3g. Name of Supervisor(s) of Activity			3h. Names of Other Present		
4. TREATMENT INFORMATION					
4a. Description of Treatment and Disposition (Light Duty, Hospitalized, Sent Home, etc.)					
4b. Medical Facility Name and Address			4c. Physician in Attendance		
5. ENDORSEMENT					
5a. Full Name, Rank and Title (Print of Type)			5b. Signature		5c. Date