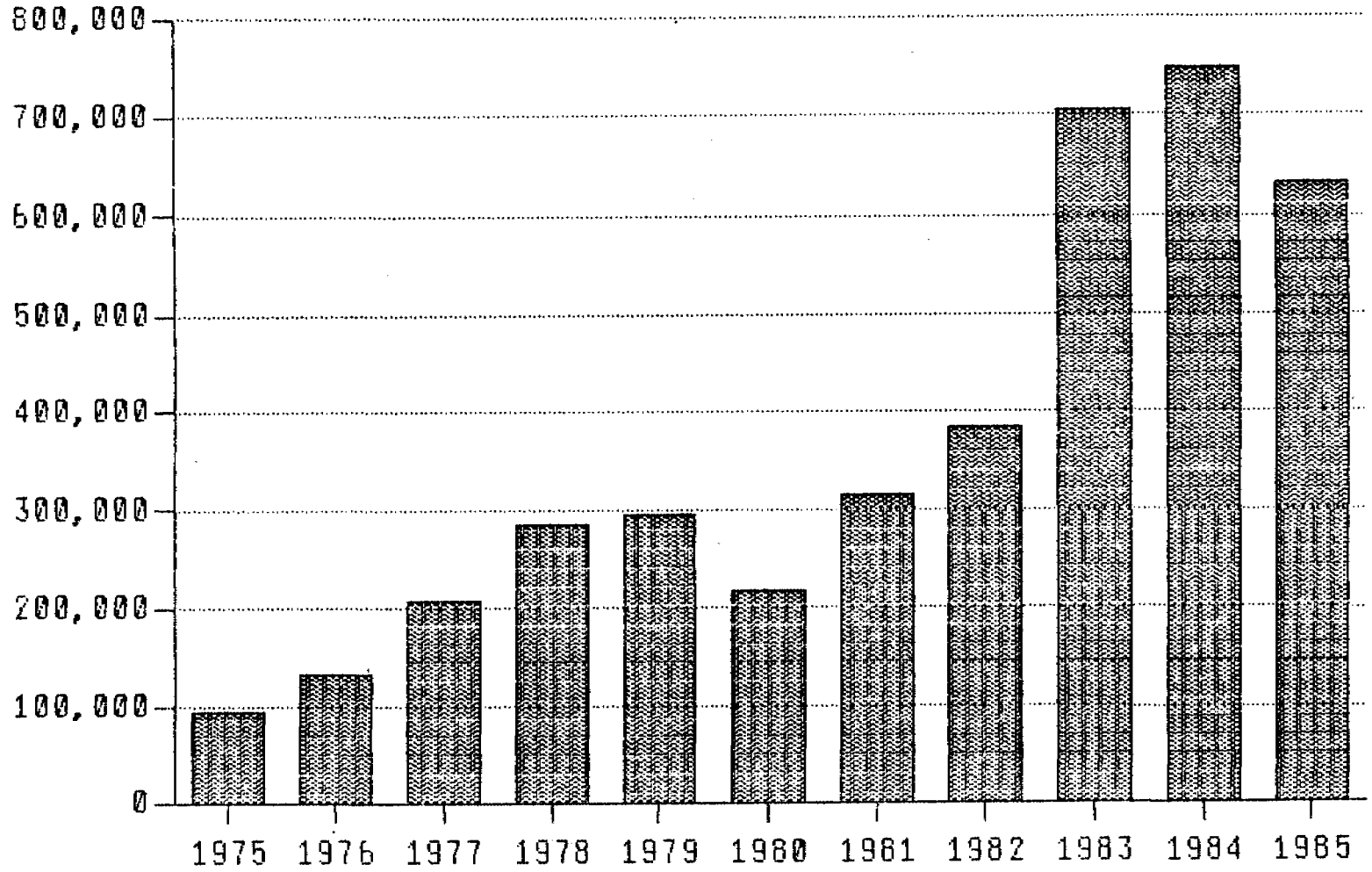
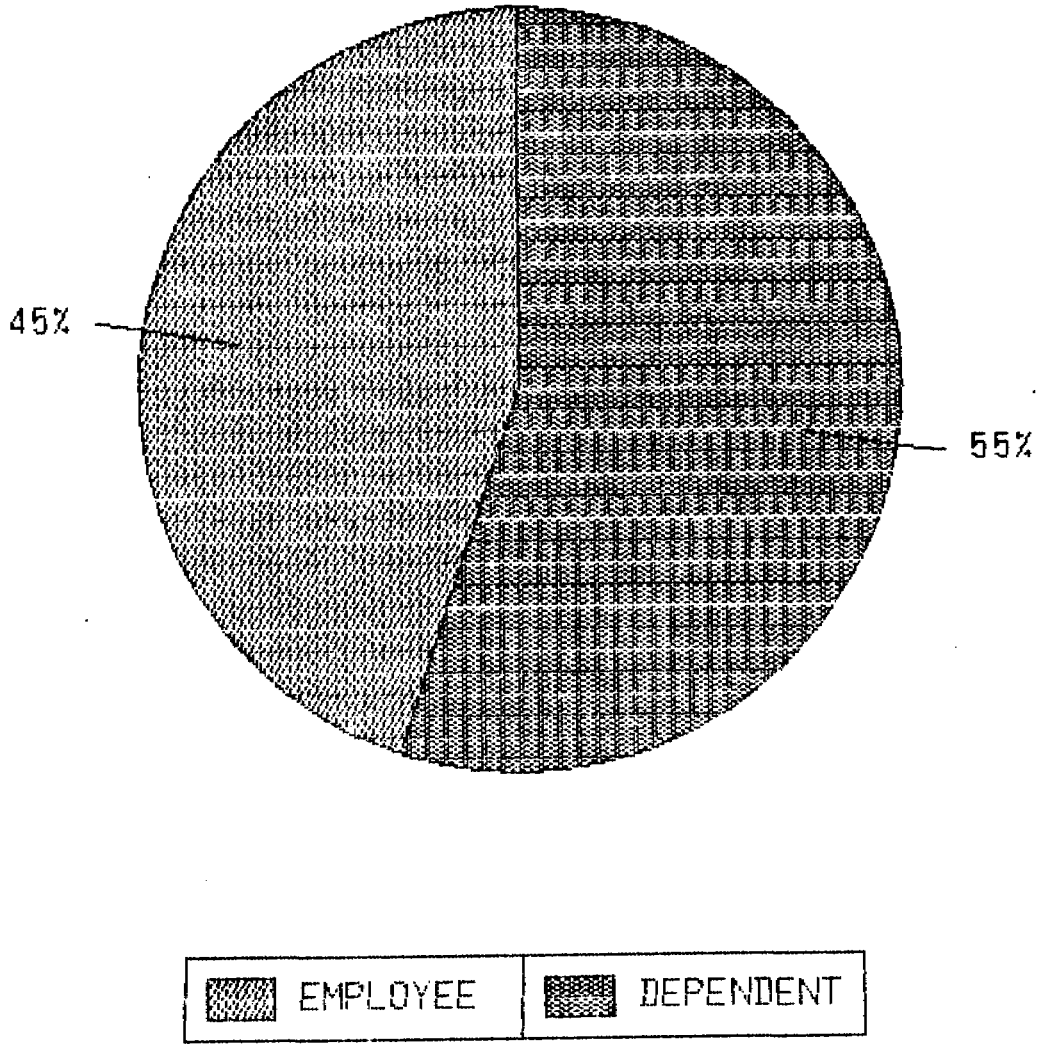
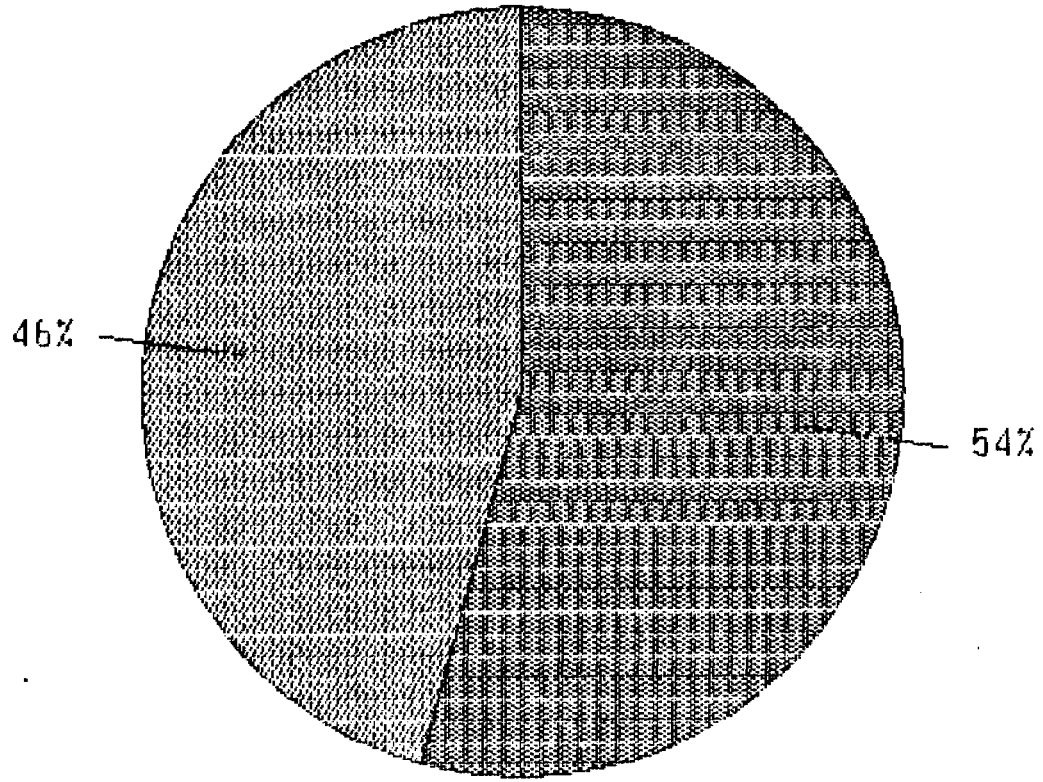
HISTORY OF ANNUAL CLAIMS
1975-1985



EMPLOYEE AND DEPENDENT CLAIMS PAID IN 1985



IN-PATIENT VS OUT-PATIENT CHARGES



GROUP HEALTHCARE PLAN BENEFITS FOR EMPLOYEES AND DEPENDENTS

HIGHLIGHTS

The Ambassador College/Worldwide Church of God Healthcare Benefits Plan offers:

- o employee contributions paid for you by your employer and dependent contributions paid by you through payroll deductions;
- o comprehensive insurance protection for hospital and medical bills when you or your covered dependents need healthcare services;
- o a maximum lifetime benefit of $250,000 per person, which includes $15,000 maximum for mental and nervous conditions.

PURPOSE OF THE PLAN

The Plan is primarily intended to assist employees in the payment of medical bills which result from catastrophic disabilities as well as from ordinary injuries or diseases, regardless of the number of injuries or diseases suffered. Benefits are payable not only for expenses arising in the hospital but also for many medical charges which are not a part of a hospital bill and which frequently are not covered by other plans.

WHO IS ELIGIBLE

All regular, full-time employees working at least thirty (30) hours per week are eligible for coverage on the date of employment. Your eligible dependents are your spouse and your unmarried, dependent children to age nineteen (19). Full-time students are eligible until age twenty-three (23) as long as they are unmarried and dependent upon you for support.

No person is eligible for benefits both as an employee and as a dependent, nor as a dependent of more than one employee. If both you and your spouse are employees of Ambassador College/ Worldwide Church of God, or another participating corporation, you will both have your coverage paid for by your employer. In this instance, if you have children, one parent must arrange for payroll deductions for "child(ren) only" coverage.

HOW YOU ENROLL

To join the plan, fill out the enrollment card you will receive. If you do not enroll within thirty-one (31) days of date of hire, you and your dependents will be required to complete a form providing proof of your insurability. (You will be required to complete a questionnaire on your medical history and, if necessary, a physical exam at your own expense.)

The following classifications apply to your coverage:

- o employee only
- o employee and spouse only
- o employee and child(ren) only
- o employee, spouse and child(ren)

When you enroll for dependent coverage, **all eligible dependents must be covered.** For example, an employee with a spouse and children may not select "spouse only" or "child(ren) only" but must select "spouse and child(ren)" coverage.

Newly acquired dependents may be added without evidence of their insurability if you enroll them within thirty-one (31) days after they first become eligible dependents.

Changes in the number of your dependents should be reported to the Personnel Office immediately so that your coverage and payroll deductions can be adjusted.

WHAT THE PLAN PAYS

- o For Accidents or Illnesses: The Plan pays 80% of the reasonable and customary* charges for eligible expenses after you pay the first $350 (the deductible) of covered charges in a calendar year. Once the deductible has been satisfied, the Plan pays 80% of the next $5,000 in covered medical expenses. The remaining 20%, or $1,000, is paid by you. Any covered expenses you incur in excess of $5,000 per calendar year, will be paid by the Plan at 100%.

- o For Nutritional Supplements: Nutritional supplements prescribed by a licensed physician in connection with treatment for illness or injury will be reimbursed at 60% by the Plan, after you have satisfied the deductible. The maximum benefit for nutritional supplements is $600 per calendar year per family.

*(See definition of Reasonable and Customary, page 11.)

HOW THE DEDUCTIBLE WORKS

The deductible is $350 per person, subject to a maximum family deductible of $700 per year. Before the Plan pays on eligible expenses, you pay the first $350 of eligible expenses every calendar year. A special feature of the Plan is the three (3) month carry-over. Any covered expenses incurred and charged against the deductible during the last three (3) months of a calendar year will also apply toward meeting your deductible for the next calendar year.

WHAT ARE THE MAXIMUM BENEFITS

Each person covered by the Healthcare Plan is protected by a $250,000 Lifetime Maximum Benefit for all eligible medical expenses, except for treatment of mental and nervous conditions. Whenever benefits are paid, they are charged against that person's overall maximum.

Included in the Maximum Lifetime Benefit for eligible expenses due to nervous and mental conditions is $15,000 per individual.

WHAT THE PLAN COVERS

Covered expenses are the reasonable and customary fees for those medical services eligible for full or partial reimbursement from the Plan. Reasonable and customary charges are the usual rates in the area where the treatment or service is performed. (The deductible applies per person, including newborn infants.)

Covered expenses include the reasonable and customary charges for:

- room and board and routine nursing charges for confinement in a hospital up to the hospital's semi-private room rate; however, expenses incurred for intensive care units will be considered at the actual charge, subject to the applicable coinsurance percentage;
- expenses in connection with routine physical exam not more than once every twenty-four (24) months;
- necessary hospital services and supplies furnished by the hospital during confinement;
- hospital charges relating to the care of a newborn infant for the first five (5) days following birth. Pediatric exam by a legally licensed physician of a newborn child while hospitalized and up to five (5) visits for pediatric care in the twelve (12) months following birth;

- convalescent facility charges for confinement following an in-hospital stay, maximum of ten (10) days at 50% of the semi-private rate in the last hospital;

- services of a legally qualified physician (see definition on page 11); surgery; home, office, hospital visits; and other medical care are included. Services of a registered, graduate nurse (RN) other than a nurse who ordinarily resides in your home, or who is a member of your family or your spouse's family;

- nutritional supplements prescribed by a licensed physician (or recommended in writing in the case of chiropractors), in connection with treatment for illness or injury. Covered expenses in this category will be reimbursed at 60% by the Plan (after the deductible is satisfied) with a maximum amount allowable of $600 per family per calendar year. The following services and supplies are covered:

  - diagnosis of vitamin or mineral imbalance;

  - diagnosis of toxic or allergic reactions to natural or artificial substances;

  - purchase and administration of vitamins or minerals to correct body imbalance or preserve an acceptable balance;

  - administration of natural or artificial substances to remove or prevent the presence of toxic or allergy-inducing substances in the body;

- services and supplies, including:

  - drugs and medicines available only by prescription;

  - anesthetics and oxygen and their administration;

  - rental of iron lung and other durable medical or surgical equipment;

  - x-ray examinations and laboratory tests;

  - physiotherapy;

  - artificial limbs and artificial eyes;

  - x-ray, radium, and radioactive isotope therapy;

- professional ambulance service when used to transport an individual from the place he is injured or stricken ill to the first hospital where treatment is given; however, no other expense in connection with travel is covered;

- hospital and other medical expense such as dental work or oral surgery resulting from non-occupational injury to natural teeth (teeth that have had no previous decay and/or repair), and/or related bodily tissues. In addition, depending on the nature of the dental problem, the following surgical procedures are covered:
  - excision of partially or completely unerupted, impacted teeth;
  - excision of a tooth root (root canal) without the extraction of the entire tooth;
  - other incision or excision procedures on the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth.

WHAT THE PLAN DOES NOT COVER

While your Healthcare Plan provides a wide range of benefits, some excluded services are:

- hospital and other medical expenses for any pre-existing condition (see definition on page 11) until three (3) consecutive months have passed (beginning and ending after your effective date) without treatment for that condition, or until your insurance has been in effect for twelve (12) months, whichever comes first;
- eye examinations made in connection with diagnosis or treatment of astigmatism, myopia or hyperopia;
- fitting or cost of eyeglasses or hearing aids, except when necessitated by damage to the natural eye or ear as a result of an injury which occurs while covered under the Plan;
- out-of-hospital or out-patient hospital services for mental and nervous disorders;
- charges for custodial care (see definition on page 11);
- charges made by a physician (see definition on page 11), if such person is related to the employee or dependent or ordinarily resides with the person requiring treatment;
- injury or sickness resulting from war or any act of war, whether declared or undeclared;
- plastic or cosmetic surgery, except those expenses arising from disease or accidental injury while covered under the Plan, or the correction of a congenital deformity in a newborn who is covered from birth under the Plan;

- non-surgical expenses for dental work; dental expenses which are not in connection with an injury to natural teeth (teeth which have had no previous decay and/or repair).

- expenses which are not certified as being medically necessary by the attending physician, or charges made by a hospital unless the hospitalization is recommended and approved by a physician;

- any disability covered by workers' compensation, and/or caused or aggravated by any occupation or employment;

- any services or supplies for which you are not required to pay.

MATERNITY

Covered medical expenses under the Plan apply to each pregnancy of a covered female employee or dependent wife. A pregnancy which commences prior to the effective date of coverage will be subject to the pre-existing condition limitation (see page 5 -- "What the Plan Does Not Cover").

NERVOUS AND MENTAL DISORDERS

In-hospital care is covered under the normal provisions of the Plan up to a $15,000 lifetime maximum per individual. No benefits are included for out-of-hospital services under the Plan (including out-patient hospital services).

WHEN YOUR INSURANCE BEGINS

Your insurance will begin on the date you become eligible and your completed card has been returned to the Personnel Office.

If you are absent from work the day your insurance should become effective, coverage will begin the day you return to active, full-time work.

Coverage begins for your dependent on the latest of the following dates:

- the date your insurance coverage begins;

- the date your request for dependent coverage is received by the Personnel Office;

- the date he or she becomes an eligible dependent;
- the date proof of your dependent's insurability is approved.

Newborn children are covered from birth if dependent coverage is in effect. You must enroll newborn children within thirty-one days after birth. To do so, contact the Personnel Office.

WHEN YOUR INSURANCE TERMINATES

Your insurance will terminate on the earliest of the following dates:

- the date the policy terminates;
- the date you cease to be an active permanent employee regularly working at least thirty (30) hours per week;
- the date you enter full-time military, naval or air service;
- the date you retire.

Coverage for your dependent(s) terminates on the earliest of the following dates:

- the date your insurance terminates;
- the date your dependent ceases to qualify as a dependent;
- the last day for which you, as the employee, have made the required contribution toward the cost of dependent coverage;
- the date your dependent becomes insured under the Plan as an employee.

IF YOU OR YOUR DEPENDENT BECOME TOTALLY DISABLED

If you or a dependent become totally disabled while you are an active employee, coverage under the Healthcare Plan will continue until the earlier of:

- the date the individual is no longer totally disabled, or
- eighteen (18) months from the date the disability started.

If you or your dependent are totally disabled on the date coverage under the Healthcare Plan stops, certain benefits are continued if the individual is totally disabled as a result of a non-occupational injury or illness. Specifically, benefits

will continue for those expenses resulting from the cause of total disability. This extension of benefits will end the earliest of:

- o when the individual is no longer totally disabled, or
- o when the individual becomes eligible for benefits for disability under another group policy or program, or
- o twelve (12) months after insurance is terminated.

MEDICARE COVERAGE

All active, full-time employees 65 years of age and older are covered by the Healthcare Plan as their primary source of insurance. Medicare will only pay after the Healthcare Plan pays.

However, it is very important that you sign up for Medicare several months prior to your sixty-fifth (65th) birthday so that your Medicare coverage is in effect when you turn age sixty-five (65). Please contact your local Social Security Office for specific information concerning your Medicare benefits and the penalties you will encounter if you have not signed up for Medicare coverage by your sixty-fifth (65th) birthday.

IF YOU ARE COVERED BY ANOTHER PLAN

Many families are covered under more than one group medical plan. If this applies to you and your dependents, benefits paid by your Healthcare Plan will be coordinated with your other group insurance so that duplicate benefits are not paid forthe same expenses. This "Coordination of Benefits" provision ensures that you get the benefits to which you are entitled and that benefits exceeding the expenses incurred are not paid.

When you file a claim for benefits under your Healthcare Plan, you should also file a claim with any other group insurance plan you have. On both claim forms, you must indicate the name of all other group plans and the employer, union or association sponsoring the plans.

WHICH PLAN PAYS FIRST

The order of payment of benefits depends on the patient's position or relationship. Generally,

- o if you are the patient, the Healthcare Plan usually will pay first;
- o if your spouse is employed and is the patient, your spouse's plan will usually pay first;
- o if you and your spouse are both employed and your dependent-covered child receives care, the father's plan pays first even if the dependent is also covered under the mother's plan;
- o in the case of eligible dependents of parents who are not living together, the plan of the parent who has legal custody pays first;
- o if the other group plan does not have a coordination of benefits provision, it automatically pays first;
- o if none of the above applies, the plan covering the patient for the longest period of time will pay first.

CONVERSION PRIVILEGE

If coverage terminates for you or one of your covered dependents, and you have been covered by the Healthcare Plan for three (3) months, you have the right to convert to an individual personal health policy, without proof of insurability, within thirty-one (31) days after your coverage stops. In order to convert, you must apply to the insurance company and pay the first quarterly premium within thirty-one (31) days. The benefits provided under the conversion policy are not the same as those provided under the Healthcare Plan. Further information about benefits upon conversion is available from the Personnel Office.

HOW TO FILE A CLAIM

Claim forms are included in your claim kit. Additional forms are available from the Personnel Office, if necessary. You need only file one "Statement of Claim" form per accident or illness. When you have charges from different facilities or from on-going treatment, you should use the shorter, yellow "Subsequent Notice of Claim" form which is also enclosed. Be sure to complete the form. If you fail to give the information requested, it will cause unnecessary delays in processing your claim. Follow the instructions on the form, complete the employee portion and have the physician submit his diagnosis and treatment on his bills. For each item you submit, it is wise to make a copy for your records.

Submit the completed claim form together with related bills to:

Administrax, Inc.
23212 Mill Creek Drive
Laguna Hills, CA 92653

If you have any questions concerning the payment of your claim, or the physician or hospital wants to verify your coverage, please call Administrax, Inc. directly at:

(800) 432-8879 -- California calls only
(800) 426-8979 -- Continental USA
(213) 687-0734 -- Alaska or Hawaii
(714) 951-1175

A separate claim form should be submitted for each family member for whom a claim is being made. In addition, all claims must include the name of the physician, date of service or expense, type of service rendered and whether the expense is due to accident or illness.

When the claim has been processed, you will receive either:

- a benefit check if benefits are payable to you, or
- a written notification of benefits paid if you have assigned them to the physician or hospital, or
- an explanation of how your expenses were considered and why benefits are not payable.

WHEN TO FILE A CLAIM

You should file medical claims with Administrax as soon as your covered medical expenses exceed the deductible. Please be prompt in filing your claim.

Be sure to state what you have paid personally. Attach an original receipt for each amount paid by you. If it is difficult to obtain a receipt, send a copy of your cancelled check along with an explanation of the corresponding <u>itemized</u> bill. An itemized bill is required.

DEFINITIONS

Convalescent Facility: An institution primarily engaged in providing services for persons convalescing from sickness or injury, with 24-hour nursing by professional nurses and under the full-time supervision of a physician or registered graduate nurse (RN). The facility is not an institution or part of one, for instance, if it is used used mainly as a rest facility or a facility for the aged.

Hospitals: A legally constituted institution licensed as a hospital (if hospital licensing is required where it is situated) open at all times and operated primarily for the care and treatment of sick and injured persons as in-patients, has a staff of one or more licensed physicians available at all times which continuously provides 24-hour nursing service by graduate registered nurses, and provides organized facilities for diagnosis and major surgery. In no event shall the term "hospital" include an institution, or part thereof, used principally as a convalescent facility, rest facility, facility for the aged, or furnishes primarily custodial care, or is operated primarily as a school.

Custodial Care: Treatment to maintain an individual at his or her present status rather than treatment to cure or improve his or her condition.

Medicare: Title XVIII of the Social Security Act.

Medicare Person: An individual who is covered under this Plan and is eligible for the Medicare program of medical care benefits. An individual shall be considered eligible for such coverage on the earliest date any coverage under Medicare could become effective with respect to that individual. A Medicare Person shall be deemed to be participating in all parts of the program for which he/she is eligible.

Physician: A licensed practitioner acting within the scope of his/her license. Physician means Doctor of Medicine or Doctor of Osteopathy, including, but not limited to a Dentist, Podiatrist, Chiropractor, Opthalmologist or Psychiatrist. All physicians must be licensed or otherwise credentialed to practice in the state where services are rendered.

Pre-existing Condition: Any illness or injury for which you received treatment or services or took prescribed drugs or medicine during the ninety (90) days preceding the effective date of coverage.

Reasonable & Customary: The usual and customary fee or charge for services rendered and supplies furnished in the geographical area where such services are rendered or supplies are furnished, provided such services and supplies are rendered and approved by a legally qualified physician or surgeon, other than the insured person.

SPECIAL PROVISIONS WHICH APPLY TO YOUR HEALTHCARE PLAN BENEFITS

REIMBURSEMENT AGREEMENT

If, in the event an employee or covered dependent is injured by another person, the employee must agree in writing to:

- reimburse the Plan to the extent of benefits provided under this Plan whenever damages are collected by legal action, settlement, or otherwise, against the person causing injury, and
- sign an "Assignment of Benefits" form so that reimbursement can be received as stated above.

July 1, 1986

AMBASSADOR COLLEGE/WORLDWIDE CHURCH OF GOD
HEALTHCARE BENEFITS PLAN #1000
EMPLOYEE STATEMENT OF CLAIM

RETURN TO:
ADMINISTRAX, INC.
ADMINISTRATORS
23212 MILL CREEK DR.
LAGUNA HILLS, CA 92653

TO BE COMPLETED BY EMPLOYEE

PLEASE NOTE: FAILURE TO COMPLETE THIS FORM IN FULL MAY DELAY PAYMENT OF YOUR CLAIM.

Minister (please print last name) John (first) Q (middle) ☒ Male ☐ Female

444 Candlewick Ave. (home address)

Lebanon, MT 59604 (city-state-zip code) (406) 351-9756 (home phone number)

7/26/39 (date of birth) 653-81-1324 (social security number)

8/30/69 (date employed) Worldwide Church of God (corporation)

YES	NO	
☒	☐	Are you married?
☐	☒	Is disability due to claimant's occupation?
☐	☒	Are you (or dependent, if a dependent claim) insured under any other group insurance policy or group plan?

N/A (other policy number) N/A (name of other insurance company or plan)

N/A (address)

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE PHYSICIAN FOR SERVICE DESCRIBED ON THE REVERSE SIDE.

John Q. Minister
SIGNED (Employee or Authorized Person)

COMPLETE ONLY IF A DEPENDENT CLAIM

Amy Sue Minister (full name of dependent) ☐ Male ☒ Female

6/6/67 (date of birth) Daughter (relationship)

If dependent is a full-time student, 19 years of age or older, give name and address of school. 16 (# units taken)

Ambassador College, Pasadena, CA 9112 (name of school / city / state / zip code)

Susie Q. Minister (spouse's name) N/A (spouse's social security no.)

N/A (name of spouse's employer)

N/A (address of spouse's employer)

COMPLETE ONLY IF ACCIDENT INVOLVED

4/25/86 (date of accident) 3:00pm (hour (am-pm)) College Gymnasium (where did accident occur?)

DESCRIBE THE ACCIDENT FULLY In final championshi volleyball game, a fast return ball struck Amy's head causing whiplash injuries to the neck.

AUTHORIZATION FOR RELEASE OF INFORMATION—GROUP MEDICAL BENEFITS

I AUTHORIZE any physician, medical practioner, hospital, Veterans Administration Hospital, clinic, other medical or medically related facility, insurance company, consumer reporting agency, employer or group policyholder having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me or my minor children and any other non-medical information of me or my minor children to give to Administrax, Inc. or its legal representative, any and all such information.

I UNDERSTAND the information obtained by use of the Authorization will be used by Administrax, Inc. to determine eligibility for benefits or services under a policy. Any information obtained will not be released by Administrax, Inc. to any person or organization EXCEPT to reinsuring companies, the Medical Information Bureau, Inc., employer, group policyholder, contractholder, or other persons or organizations performing business or legal services in connection with my claim, or as may be otherwise lawfully required or as I may further authorize.

I KNOW that I may request to receive a copy of this Authorization.

I AGREE that a photographic copy of this Authorization shall be valid as the original.

I AGREE this authorization shall be valid for two and one half years from the date shown below.

Signed this 30th day of June 19 86

Patient's Signature (if other than minor child)

John Q. Minister
Employee's Signature

HOW THE DEDUCTIBLE WORKS

Example:	Total Expenses	1,500
	Deductible	-350
		1,150
	Your Co-payment	-230
		920

Total paid by you.....$580
Total paid by the Plan.....$920

Example:	Total Expenses	15,000
	Deductible	-350
		14,650
	Your Co-payment	-1,000
		13,650

Total paid by you.....$1,350
Total paid by the Plan.....$13,650

EXPLANATION OF BENEFITS

PLEASE REFER TO THIS NUMBER WHEN CALLING →

PATIENT'S NAME:

INSURED S.S. NO:

[redacted]K NO.:

CHECK DATE:

AMOUNT PAID:

DEDUCTIBLE CALCULATION

YR.	AMOUNT	TYPE	PREVIOUSLY APPLIED	APPLIED THIS CLAIM	STILL UNSATISFI
		INDIVIDUAL MEDICAL			
		INDIVIDUAL DENTAL			
		FAMILY MEDICAL			
		FAMILY DENTAL			

EMPLOYEE

C.O.B. CALCULATION

SUBMITTED CHARGES:

PAID BY OTHER PLAN:

PAID BY THIS PLAN:

UNPAID BALANCE:

PAID BY THIS PLAN FROM SAVINGS:

DATE OF SERVICE			PROVIDER OF SERVICE	SUBMITTED CHARGE	INELIGIBLE CHARGE	Remarks Please read other side	TOTAL ELIGIBLE CHARGE PAID AT		
FROM	TO	YR.					%	%	
[redacted]									

MESSAGE:

AMBASSADOR COLLEGE/
WORLDWIDE CHURCH OF GOD
ADMINISTERED BY
ADMINISTRAX, INC.
23212 MILL CREEK DRIVE
LAGUNA HILLS, CA 92653
(714) 951-1175

16410

COMMERCEBANK
1201 DOVE STREET
NEWPORT BEACH, CA 92660

90-3731
1222

INSURED/CLAIM NUMBER	PATIENT/ACCOUNT NO.	CHECK DATE NET AMOUNT

PAY

[redacted]AY
THE
ORDER
OF

VOID

SECOND SIGNATURE (Required If Over $2,000)

⑈016410⑈ ⑆122237311⑆ 001⑈623974⑈

HEALTHCARE ADVISOR

An employer who provides the services of a Healthcare Advisor is giving a distinct and needed benefit to employees and their families.

In the case of Ambassador College/Worldwide Church of God, this service is going out to about 60 or 70 persons per week. Many participants have expressed gratitude to the Insurance Department for this service.

Although there is no way to quantify all the benefits of Healthcare Advisor activity, many positive results are produced by just two actions:

1) Encouraging employees to explore alternative treatment methods and opinions.

2) Promoting the concept of being in charge of their own case--of increased involvement and responsibility in examinations, treatments, procedures and financial matters.

There have been dozens of instances where Advisor direction or intervention has produced considerable savings. Here are just a few examples:

One man, when purchasing a home healthcare device, saved $885 (83%) through Advisor research and guidance.

Another employee, acting on Advisor counsel, converted an $8,500 in-patient surgery to a $2,500 out-patient surgery (saved 71%).

Another saved $2,000 on his wife's hospital bill through following Advisor suggestion to settle for a 25% cash discount.

A young female employee saved $704 (100% of her bill), through Advisor intervention when a doctor and hospital had mishandled her case. She originally went in for a $21 blood test and was coerced into a full gynecological exam.

A male employee saved $269 (25%) by Advisor assistance where a nurse had kept him in the hospital overnight by threatening his insurance wouldn't pay if he signed himself out.

A man's son was billed $2,075 for one hour in the emergency room. Advisor research revealed overcharging. The hospital willingly settled for $1,000 cash (a 52% reduction).

A doctor's office billed eleven months after date of service for psychological visits forced on a hospital patient. Advisor assistance resulted in the doctor's office readily settling for 50% cash ($145 saved).

PATIENT'S BILL OF RIGHTS
(and responsibilities)

YOU HAVE A RIGHT TO:

1. Receive a full, understandable explanation of your medical condition, the proposed treatment plan and recovery.
2. Be apprised of risks associated with a treatment plan.
3. Know the estimated cost of a treatment plan and have the final bill explained in detail.
4. Refuse treatment.
5. Know the names and credentials of all people involved in your case.
6. Courteous and respectful care.
7. An appropriate, well-managed course of treatment.
8. Have your medical records kept confidential.
9. Choose and change physicians or institutions.

YOU HAVE A RESPONSIBILITY TO:

1. Ask questions about prescibed procedures, tests or other care.
2. Ask for a second opinion if the treatment carries a risk.
3. Be courteous and reasonable in your requests.
4. Use the healthcare system wisely and appropriately.
5. Obtain and complete all forms and paperwork necessary for payment.
6. Pay for services received.
7. Maintain your health.

HEALTHCARE

SUGGESTED READING LIST

Worldwide Church of God booklets:

* Principles of HEALTHFUL LIVING 1985 Edition
* The Seven Laws of SUCCESS Pages 24-28

Books

* CONFESSIONS OF A MEDICAL HERETIC 1979
  By Robert S. Mendelsohn, M.D.

  Available in bookstores $4.50 Paperback, Warner Books

* TAKE THIS BOOK TO THE HOSPITAL WITH YOU 1985
  By Charles B. Inlander

  Available in bookstores $9.95 Paperback, Rodale Press

* HEALTHCARE COSTS: There Are Solutions 1983
  By W. Bryan Latham, M.D.

  Available through the Insurance Department $3.75

WORKERS' COMPENSATION INFORMATION

WHO'S COVERED

All employees of the Worldwide Church of God, Ambassador College and Ambassador Foundation are protected by Workers' Compensation. People in business for themselves and unpaid volunteers are not covered.

WHAT'S COVERED

An injury or illness is covered if it's due to your job. Not just the serious accidents, but even first-aid type injuries are covered.

Coverage is automatic and immediate. There's no qualifying period, no need to earn so much in wages before you're covered -- the protection begins with your first minute on the job.

WHAT YOU HAVE TO DO

All that's necessary is to notify the Personnel Office immediately when you've been injured. Prompt reporting is the key to prompt benefits. They will send you a form (see attached example) which needs to be completed for internal reporting purposes. This should be completed prior to receiving medical care, if possible, and sent to Personnel.

July 1, 1986

Occupational Injury/Illness Report

PERSONNEL OFFICE

Instructions: 1. This form must be filled in by the employee's immediate supervisor. **2.** California law requires an employer to report immediately every industrial injury or occupational disease which: (A) requires medical treatment other than minor first aid or (B) results in lost time beyond the day of injury. In addition, if the injury results in death, a report must be made immediately to the Personnel Office by telephone (304-6100). **3.** Supervisor must submit completed report to the Personnel Office.

Employee's last name	First	Middle	Employee number	Social Security number
Minister	John	Q	10007	653 81 1324

Street address: 444 Candlewick Avenue

City	State	Zip
Lebanon	Mt	59604

Birthdate					Home phone number
7/26/39	☒ Male	☐ Female	☒ Married	☐ Single	(406) 351-9756

Occupation	Department	Date hired	Wage per week
Minister	U.S. Churches	8/30/69	600.00

DATE OF INJURY/ILLNESS: 6/23/86 TIME OF DAY: 4:30 ☐ A.M. ☒ P.M.

Where did accident or exposure occur? (ADDRESS, CITY, AND COUNTY)

Lebanon Union High School Gymnasium

200 S. Fremont, Lebanon, MT, Linn County

IS THIS ON THE EMPLOYER'S PREMISES? ☐ Yes ☒ No

What was employee doing when accident or exposure occurred? (PLEASE BE SPECIFIC — IDENTIFY TOOLS, EQUIPMENT OR MATERIAL EMPLOYEE WAS USING)

Refereeing a church-sponsored youth basketball game. During the second half, my knee popped out of joint as I was running down the court.

How did accident or exposure occur? (PLEASE DESCRIBE FULLY THE EVENT, UNSAFE ACTS OR UNSAFE CONDITIONS THAT RESULTED IN INJURY OR OCCUPATIONAL DISEASE. TELL WHAT HAPPENED AND HOW IT HAPPENED. PLEASE USE A SECOND SHEET IF NECESSARY)

Refereeing a basketball game. My knee popped out of joint.

Describe object or substance that directly affected employee (E.G., THE MACHINE EMPLOYEE STRUCK AGAINST OR WHICH STRUCK HIM; THE VAPOR OR POISON INHALED OR SWALLOWED; THE CHEMICAL THAT IRRITATED THE SKIN; IN CASE OF STRAINS, THE OBJECT HE WAS LIFTING OR PULLING, ETC.)

Running

Indicate nature of injury or illness and part(s) of the body affected

Right knee

DID EMPLOYEE DIE?	Date of death	IF NO, WAS HE/SHE UNABLE TO WORK ON ANY DAY AFTER INJURY?	Date last worked	HAS EMPLOYEE RETURNED TO WORK?	Date returned
☐ Yes ☒ No		☐ Yes ☒ No		☒ Yes ☐ No	6/25/86

WILL EMPLOYEE HAVE WORK RESTRICTION?	If yes, restriction date from:	Full-time return date
☐ Yes ☒ No		

Name and address of attending physician

Dr. Ames, 354 54th St. Suite 202, Lebanon, MT 59604

Name and address of hospital used

Lebanon Memorial Hospital

606 River Road, Lebanon, MT 59604

EMPLOYEE'S SUPERVISOR:	Signature	Title	Date
	X [signature]	Director of Church Admin.	6/30/86

FILING OF THIS FORM IS NOT ADMISSION OF LIABILITY

Occupational Injury/Illness Report

PERSONNEL OFFICE

Instructions: **1.** This form must be filled in by the employee's immediate supervisor. **2.** California law requires an employer to report immediately every industrial injury or occupational disease which: (A) requires medical treatment other than minor first aid or, (B) results in lost time beyond the day of injury. In addition, if the injury results in death, a report must be made immediately to the Personnel Office by telephone (304-6100). **3.** Supervisor must submit completed report to the Personnel Office.

Employee's last name	First	Middle	Employee number	Social Security number

Street address

City | State | Zip

Birthdate	☐ Male ☐ Female	☐ Married ☐ Single	Home phone number ( )

Occupation	Department	Date hired	Wage per week

DATE OF INJURY ILLNESS | TIME OF DAY ☐ A.M. ☐ P.M.

Where did accident or exposure occur? ADDRESS, CITY, AND COUNTY

IS THIS ON THE EMPLOYER'S PREMISES. ☐ Yes ☐ No

What was employee doing when accident or exposure occurred? (PLEASE BE SPECIFIC — IDENTIFY TOOLS, EQUIPMENT OR MATERIAL EMPLOYEE WAS USING)

How did accident or exposure occur? (PLEASE DESCRIBE FULLY THE EVENT, UNSAFE ACTS OR UNSAFE CONDITIONS THAT RESULTED IN INJURY OR OCCUPATIONAL DISEASE. TELL WHAT HAPPENED AND HOW IT HAPPENED. PLEASE USE A SECOND SHEET IF NECESSARY)

Describe object or substance that directly affected employee (E.G. THE MACHINE EMPLOYEE STRUCK AGAINST OR WHICH STRUCK HIM; THE VAPOR OR POISON INHALED OR SWALLOWED; THE CHEMICAL THAT IRRITATED THE SKIN. IN CASE OF STRAINS, THE OBJECT HE WAS LIFTING OR PULLING, ETC.)

Indicate nature of injury or illness and part(s) of the body affected

DID EMPLOYEE DIE? ☐ Yes ☐ No Date of death	IF NO, WAS HE/SHE UNABLE TO WORK ON ANY DAY AFTER INJURY? ☐ Yes ☐ No Date last worked	HAS EMPLOYEE RETURNED TO WORK? ☐ Yes ☐ No Date returned

WILL EMPLOYEE HAVE WORK RESTRICTION? ☐ Yes ☐ No	If yes, restriction date from:	Full-time return date:

Name and address of attending physician

Name and address of hospital used

EMPLOYEE'S SUPERVISOR:	X Signature	Title	Date

AC 982-1

FILING OF THIS FORM IS NOT ADMISSION OF LIABILITY