



CODE OF CONDUCT

Each team member needs to complete this form.



As a follower of the Lord Jesus, our conduct should be a witness to others of a transformed life. Paul wrote to Titus,

*And show your own self in all respects to be a pattern and a **model of good deeds and works**, teaching what is unadulterated, showing gravity (having the strictest regard for truth and purity of motive), with dignity and seriousness. And let your instruction be sound and fit and wise and wholesome, vigorous and irrefutable and above censure, so that the opponent may be put to shame, finding nothing discrediting or evil to say about us (Titus 2:7-8, Amplified Bible, emphasis added).*

As a Church Mobilization - Church Teams member, I realize the important role I serve as an example to those in the United States. I understand that I represent not only my local church, but also Assemblies of God U.S. Missions and most importantly, Jesus Christ. In respect to this assignment, I will refrain from anything (e.g., alcohol, tobacco, unwholesome speech) that may distract from my Christian testimony, cause division, or demonstrate disrespect to the church, missionary personnel, my team, or the Assemblies of God. I promise to forgo my personal convictions on these subjects in order to maintain unity and to avoid controversy in the body of Christ.

I affirm that I do not have any criminal convictions or allegations related to sexual misconduct with an adult or minor, nor do I know of any reason I should not be allowed to work with adults or minors as a short-term missions volunteer.

I have read and understand the above policy.

Name

Signature

Date

Sending church name

ASSUMPTION OF RISK, RELEASE, AND INDEMNITY AGREEMENT
Domestic Travel

What an honor it is to have you volunteer for missionary service. We want to acquaint you with the philosophy and expectations of Assemblies of God. We also want to give you the opportunity to fully evaluate the undeniable fact that times of extreme stress and crisis will come that could cause you to question whether or not you would have participated on this mission if you had known all the facts. It is impossible to predict, fully prepare you, or furnish you with all aspects of what you may face. We have, therefore, prepared some basic assumptions which we both must make. Please prayerfully consider the following assumption statement before signing and returning it to Assemblies of God. Your application cannot be processed without the proper signatures on this form.

Participant Information
(Please Print Legibly)

Name of Participant: _____ Email: _____
Address: _____ Telephone: _____
Name of Emergency Contact: _____
Daytime Phone: _____ Evening Phone: _____

Detailed Description of Activities:

TRANSPORTATION (AS OF THIS DATE), SUBJECT TO CHANGE:

ACTIVITIES INCLUDING BUT NOT LIMITED TO:

Dates and Locations of Activities:

I, _____ IN CONSIDERATION of my acceptance as a volunteer on this missionary trip in cooperation with the Assemblies of God, and other considerations the sufficiency of which is acknowledged, represent and agree that:

1. Status. I am a volunteer and/or self-employed worker and acknowledge that I am not traveling as an employee of the General Council of the Assemblies of God.

I attest and certify that I am physically fit and have no medical conditions that would prevent me from participating in the above-referenced activity.

2. Risks of travel. I am aware of the hazards and risks to my person and property associated with serving in a missions capacity, such hazards and risks including but not being limited to injury; increased stress; accident; disease; inadequate medical services and supplies; death; criminal acts (including terrorism); natural disasters; weather conditions; government action; risks of traveling to or from destinations. I recognize that I may be subjected to potential risks, illnesses, injuries, and even death. I have made my own investigation of these risks, understand these risks, and assume them knowingly and willingly. I further recognize that such risks have always been associated with missionary service. (2 Corinthians 11:23-28)

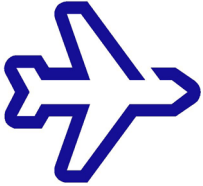
I also acknowledge that in working, living and traveling in cities, I may experience problems associated with urban living, including increased crime, pollution, high population density or standards of living and health standards that are different from those to which I am accustomed. I acknowledge that it is my responsibility to take every precaution to safeguard my health and to protect my personal belongings from damage or theft. I acknowledge that Assemblies of God recommends that I never travel alone, particularly at night. Being alone, especially at night, may present additional danger to my safety and well-being.

I understand and agree that if, during my participation in the above-described activities, the travel leader learns that I am experiencing serious health problems, have suffered an injury, or am otherwise in a situation that raises significant health and safety concerns, then the travel leader may contact the person whose name I have provided as my "emergency contact." I understand that the travel leader ordinarily will not initiate such contact without first having a discussion with me.

3. GENERAL RELEASE AND ASSUMPTION OF RISK:

KNOWING THE RISKS DESCRIBED ABOVE, I AGREE, ON BEHALF OF MY FAMILY, HEIRS, AND PERSONAL REPRESENTATIVES, TO ASSUME ALL THE RISKS AND RESPONSIBILITIES SURROUNDING MY PARTICIPATION IN THE ABOVE-DESCRIBED ACTIVITIES, BOTH KNOWN AND UNKNOWN. TO THE MAXIMUM EXTENT ALLOWED BY LAW, I RELEASE, HOLD HARMLESS, AND AGREE TO INDEMNIFY THE GENERAL COUNCIL OF THE ASSEMBLIES OF GOD, AND IT'S AFFILIATED MINISTRIES, AND ANY ASSEMBLIES OF GOD CHURCH AND/OR DISTRICT COUNCIL, AND ANY ASSEMBLIES OF GOD SCHOOL, COLLEGE OR UNIVERSITY, AND THEIR OFFICERS, DIRECTORS, EMPLOYEES, VOLUNTEERS, AND AGENTS, FROM AND AGAINST ANY PRESENT OR FUTURE CLAIMS, LOSSES, LIABILITIES, COSTS AND EXPENSES FOR INJURY TO PERSON OR PROPERTY, OR FOR ANY OTHER DAMAGE, WHICH I MAY SUFFER, OR FOR WHICH I MAY BE LIABLE TO ANY OTHER PERSON, RELATED TO MY PARTICIPATING IN SAID ACVITIVITIES (INCLUDING PERIODS IN TRANSIT TO OR FROM MY DESTINATIONS), RESULTING FROM ANY CAUSE, INCLUDING BUT NOT LIMITED TO NEGLIGENCE ON MY PART OR ON THE PART OF ANY OF THE RELEASED PARTIES; PROVIDED THAT THIS RELEASE OF LIABILITY SHALL NOT APPLY TO GROSS NEGLIGENCE OR WILLFUL OR WANTON MISCONDUCT.

4. **Insurance Election** - I am aware of the hazards and risks to myself associated with serving in a mission's capacity. I further understand that GC currently requires the insurance coverages summarized below, that the cost of the insurance is included with the trip, and that I am responsible for obtaining any additional insurance coverages that I consider necessary.



Mission Assure U.S. Travel / Special Events / Camps Short Term Travel

The General Council of the Assemblies of God is making a variety of travel insurance benefits available for you while participating in events sponsored and supervised by The General Council of the Assemblies of God or any church, and/or district council, school, seminary, college or university, or affiliated ministry of the Assemblies of God. Below is a brief overview of the travel insurance benefits being offered and contact information in the event of an emergency.

Who is eligible for coverage?

Class 1-Members of the Participating Organization engaged in a volunteer activity on or off premises, or sponsored activities off premises within the United States

What's covered?

Accidental Death & Dismemberment Benefits:

If, within 365 days of a covered accident, injury results in any one of the losses shown, the benefit amount shown opposite the loss will be paid. If multiple losses occur, only one benefit amount-the largest-will be paid for all losses due to the same accident.

Principal Sum
Class 1-\$10,000

Covered Loss	Benefit Amount
Life, Two or more members, Loss of use of Four Limbs	100% of the Principal Sum
Loss of use of Three Limbs	75% of the principal sum
Loss of use of Two Limbs	67% of the Principal Sum
One Member / Loss of use of One Limb	50% of the Principal Sum
Thumb and Index finger of Same Hand	25% of the Principal Sum

Additional Accident Benefits:

Coma- 1% of Principal Sum per month up to 11 months and thereafter in a lump sum of 100% of the Principal Sum.

Accident Medical Expense Benefits:

If, within 60 days of a covered accident, injury results, we will pay up to your selected benefit maximum for covered expenses. Applies only if you are traveling inside your home country.

Class 1-\$25,000

Sickness Expense Benefits:

We will pay up to your selected benefit maximum for medically necessary expenses incurred for hospital and medical care, treatment or services within 90 days of a covered sickness.

Class 1-\$2,500

We will pay benefits for covered expenses incurred within the Benefit Period as the result of Sickness when the covered person is participating in scheduled, supervised, and sponsored activities by you, including direct travel to and from such covered activities.

Additional Benefits:	Benefit Maximums
Family Reunion	\$2,500
Emergency Medical Benefits	\$10,000
Emergency Medical Evacuation	100% of covered expenses

Repatriation of Remains
100% of covered expenses

Aggregate Limit

Benefit Maximum
Per Covered Accident \$1,000,000

We will not pay benefits for any loss or injury that is caused by, or results from: · intentionally self-inflicted injury, while sane. (Applicable to Accidental Death and Dismemberment Benefit only) · Suicide or attempted suicide. (Applicable to Accidental Death and Dismemberment Benefit only) · War or any act of war, whether declared or not. · A covered accident that occurs while on active duty service in the military, naval, or air force of any country or international organization. Upon our receipt of proof of service, we will refund any premium paid for this time. Reserve or National Guard active duty training is not excluded unless it extends beyond 31 days. · sickness, disease, bodily or mental infirmity, bacterial or viral infection, or medical or surgical treatment thereof, except for any bacterial infection resulting from an accidental external cut or wound or accidental ingestion of contaminated food. · Piloting or serving as a crewmember in any aircraft (except as provided by this proposal). · Commission of, or attempt to commit, a felony. · eyeglasses, contact lenses, hearing aids, wheelchairs, braces, appliances, examinations, or prescriptions for them. · travel or activity outside the United States. · riding in any aircraft except as a fare-paying passenger on a regularly scheduled or charter airline. · commission of or active participation in a riot or insurrection. · Injury paid by Workers' Compensation, Employer's Liability Laws, or similar occupational benefits. · Injury or loss contributed to the use of any drugs or narcotic, except as prescribed by a doctor.

We will not pay Sickness Benefits for any loss, treatment, services or supplies resulting from, or contributed to by: · immunizations, services and supplies related to immunizations; · acupuncture, allergy, including allergy testing, or alpecia; · non-malignant warts, moles, lesions or acne; · care of corns and bunions; · sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation; · submucous resection and/or other surgical correction for deviated nasal septum, other than for required treatment of acute purulent sinusitis; · eyeglasses, contact lenses, hearing aids, or prescriptions or examinations therefore Radial Keratotomy/Lasik surgery is not covered; · voluntary or elective abortion; · congenital birth defects; · elective treatment or elective surgery; and · routine physical examinations and dental care.

In addition to the general exclusions, we will not pay Accident Medical Expense Benefits for any loss, treatment, or services resulting from or contributed to by: · treatment by persons you employ or retain or by any immediate family member or member of the covered person's household. · treatment of sickness, disease, or infections except pyogenic infections or bacterial infections that result from the accidental ingestion of contaminated substances. · treatment of hernia, Osgood-Schlatter disease, osteochondritis, appendicitis, osteomyelitis, cardiac disease or conditions, pathological fractures, congenital weakness, detached retina unless caused by an injury, or mental disorder or psychological or psychiatric care or treatment (except as provided in this proposal), whether or not caused by a covered accident. · pregnancy, childbirth, miscarriage, abortion, or any complications of any of these conditions. · mental and nervous disorders (except as provided in this proposal). · damage to or loss of dentures or bridges or damage to existing orthodontic equipment (except as specifically covered by this proposal). · expenses incurred for treatment of temporomandibular or craniomandibular joint dysfunction and associated myofascial pain (except as provided by this proposal). · injury covered by workers' compensation, employers' liability laws, or similar occupational benefits or while engaging in activity for monetary gain from sources other than you. · injury or loss contributed to by the use of drugs unless administered by a doctor.

This insurance does not apply to the extent that trade or economic sanctions or other laws or regulations prohibit Us from providing insurance, including, but not limited to, the payment of claims.

Important Notice

This information is a brief description of the important features of the insurance plan. It is not a contract of insurance. The terms and conditions of coverage are set forth in the policies issued in the state in which the policy was delivered. Complete details may be found in the policies on file at AG Financial's office. Insurance Benefits are underwritten by ACE American Insurance Company. The policy is subject to the laws of the state in which it was issued. Coverage may not be available in all states or certain terms may be different if required by state law. Please keep this information as a reference.

5. Minor children. In the event that I have minor children who will accompany me on my assignment, I take full responsibility for their supervision and conduct at all times, and I, acting both on my own behalf and on their behalf as their parent and legal guardian, do hereby assume all risks of death, illness, or injury that they may suffer as a result of said assignment, from those causes described above.
6. I expressly waive any defense to the enforcement of any provision of this commitment arising from a claim of lack of consideration and warrant that this commitment constitutes a legal, valid, and binding obligation upon me enforceable against me in accordance with its terms.
7. Invalidation of any one or more of the provisions of this Agreement shall in no way affect any of the other provisions hereof, which shall remain in full force and effect.
8. I expressly agree that this assumption of risk, release, and indemnity agreement is intended to be as broad and inclusive as permitted by law. I further state that I HAVE CAREFULLY READ THIS AGREEMENT AND UNDERSTAND ITS CONTENTS, AND I VOLUNTARILY SIGN THIS AGREEMENT AS MY OWN FREE ACT.

I certify that I am age 18 or older. I understand and agree that no oral or written representations can or will alter the contents of this document. This Agreement shall be governed and construed in accordance with the laws of the State of Missouri, excluding its choice of law rules, and all claims relating to or arising out of this Agreement, including claims for injuries or wrongful death in any way related to the above-described activities, shall likewise be governed by the laws of the State of Missouri, excluding its choice of law rules.

Signature of participant

Printed name of participant

Witness signature

Date witnessed



ACE American Insurance Company
Philadelphia, PA 19106

BENEFICIARY DESIGNATION/CHANGE FORM

The insurance company automatically designates beneficiaries to the first surviving class of the following class of persons: your spouse; your child or children; your mother or father; your sisters or brothers; and finally, your estate. **If you wish to designate your beneficiaries differently than this sequence**, you must complete this form and return it to the Policy Holder.

Policy Information	
Policy Number:	Policy Effective Date:

Insured Information			
Insured Name:	Social Security No.:	Home Phone Number:	Work Phone Number:
Address:			

Primary Beneficiary Information			
List your beneficiary(ies) and the percentage payable to each. If no percentage is indicated, the beneficiaries will share the benefit equally.			
Name	Social Security No.	Relationship	Percentage
Total:			0

Contingent Beneficiary Information			
A contingent beneficiary will only receive a benefit if all primary beneficiaries are deceased. The contingent beneficiary for all benefit plans is your estate unless you choose another beneficiary. If you choose a contingent beneficiary other than your estate, list this beneficiary(ies) and the percentage payable to each below. If no percentage is indicated, the beneficiaries will share the benefit equally.			
Name	Social Security No.	Relationship	Percentage
Total:			0

Insured's Signature: _____

Date: _____