CLAIM FORM - Accidental Death or Accidental Death & Dismemberment

INSTRUCTIONS:

1. Complete the form in full (please print).
2. Attach documents pertaining to claim (e.g., death certificate, medical bills)
3. Return completed form and documents to:

International Risk Management Group
4414 Route 202
Doylestown, PA 18902
(215)794-1488
(215)794-1498 FAX

Name of Insured Person: ____________________
Address: ____________________
Social Security Number: ____________________ Date of Birth: ____________________
Date of Loss: ____________________

Claim is being made for: DEATH: ☐
DISMEMBERMENT: ☐
If Dismemberment, please specify: ____________________
____

Describe how and where loss occurred: ____________________
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____
____

Medical Treatment: Please list all providers, services and dates

Provider's Name	Date(s) of Service	Type(s) of Service

I AUTHORIZE any physician, medical practitioner, hospital, clinic, health care facility, other medical or medically related facility, insurance or reinsuring company, the Medical Information Bureau, Inc., consumer reporting agency, or employer having information available as diagnosis, treatment, and prognosis with respect to any physical or mental condition and/or treatment of me or my minor children to give to International Risk Management Group any and all such information.
I UNDERSTAND the purpose of this Authorization is to allow International Risk Management Group to determine eligibility for life or health insurance benefits under a life or health policy. Any information obtained will not be released by International Risk Management Group, to any person or organization EXCEPT to reinsuring companies, the Medical Information Bureau, Inc., or other persons or organization performing business or legal services in connection with my policy, 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 photostatic copy of this Authorization shall be as valid as the original.
I AGREE this Authorization shall be valid for two and a half years from the date shown below.

Signature of Insured Person, Surviving Spouse or Beneficiary: ____________________

Signed this _________ day of ____________________, 20_________