Send to: International Risk Management Group
4414 Route 202
Doylestown, PA 18901
215-794-1488
215-794-1498 (Fax)

DISABILITY CLAIM FORM

Name:_____ Date of Birth:_____

Home Address:_____ Telephone:_____

Team:_____ Social Security Number:_____

Date you joined Team:_____ Position:_____

Last Game Played:_____ Date of Injury:_____

Describe circumstances of injury:_____

_____

Name and telephone number of physician: _____/_____

Expected date of recovery:_____

Under what other insurance policies are you submitting a claim?_____

AUTHORIZATION AND ACKNOWLEDGEMENT

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: _____

Signed this _____ day of _____, 20_____

ATTENDING PHYSICIAN'S STATEMENT

THE CLAIMANT MUST OBTAIN, AT HIS/HER OWN EXPENSE, THE FOLLOWING REPORT FROM A DULY QUALIFIED PHYSICIAN

Patient's Name:_____ Date of Birth:_____

Diagnosis:_____ Date of Onset:_____

Has Patient ever had same or similar symptoms?_____

Dates of **total** disability: From_____ to _____

Dates of **partial** disability: From_____ to _____

Prognosis: _____

Expected date patient will be able to return to work:_____
NOTE: "UNKNOWN" and "UNDETERMINED" are not acceptable responses; if you can not anticipate a return to work date, the disability period will not continue beyond the date of the next scheduled examination, at which time this Attending Physician's Statement must be submitted.

Any restrictions once patient returns to work? If yes, please describe:_____

_____

_____

Describe any conditions that are contributing to the symptoms/injury that caused the disability, or are hampering the normal process of recovery from same:_____

_____

_____

Date of last examination: _____

Date of next scheduled appointment: _____

Dates of Hospitalization: _____

Physicians' Name and Address (please print)_____

_____

_____

_____ _____

Signature of Physician Date Signed