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

DISABILITY CLAIM FORM

Name: _____ Date of Birth: ____/____/____

Home Address: _____

City: _____ State: _____ Zip _____ Telephone: _____

Employer: _____ Social Security Number: _____

Employer's Address: _____

Nature of Employment (Tasks & Duties): _____
_____

Last Date of Work: ___/___/___ Cause of Disability: _____

When did the cause of Disability first begin: _____

If Disability is due to accident, please describe circumstances surrounding it: _____
_____
_____

Name and address number of physician: _____

Date Disability Began: _____ 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 FOLLOWING REPORT MUST BE OBTAINED FROM A DULY QUALIFIED PHYSICIAN AT THE CLAIMANT'S EXPENSE.

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 _____

Expected date patient will be able to return to work: _____

(NOTE: "unknown" and "undetermined" are not acceptable responses; if you cannot anticipate a return to work date, the disability period will not continue beyond the date of the next scheduled examination.)

Prognosis: _____

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

_____

_____

Describe what treatment or other intervention might enable the patient to return to work:

_____

_____

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: _____

Physician's Statement: By signing this statement, I am certifying that the above-named patient is disabled from engaging in the duties of their respective occupation; (_____) for the period stated.

_____

Physician's Name and Address (please print)

_____

_____

Signature of Physician Date Signed

_____

License No.