Send to: International Risk Management Group
PO Box 2104
Doylestown, PA 18901
215-794-1488
215-794-1498 (FAX)

STATEMENT OF CLAIM BY TEAM FOR LOSS OF SERVICE

Team Name: _____

Team Address: _____

Team Tax Identification Number: _____

Authorized Team Representative: _____ Phone #: _____

Name of Insured Team Member: _____

Policy Number: _____ Date of Injury: _____

Insured Member's Status with Team Prior to injury: _____

Currently (medical clearance): _____

Date(s) and Amount(s) Claimed as Loss of Service	
Date	Amount

Total Claim Payment Requested: _____

Other Policies Providing Similar Coverage: _____

_____

_____

_____ _____

Signature of Authorized Team Representative Date Signed