MEDICAL EXPENSES CLAIM FORM
Group Hospital - Surgical - Medical
International Risk Management Group
PO Box 2104
Doylestown, PA 18901
(215)794-1488

INSTRUCTIONS:
1. Complete the Member's Statement Below.
2. Return form and attachments to:
   International Risk Management Group
   PO Box 2104
   Doylestown, PA 18901

(PLEASE PRINT) PART A TO BE COMPLETED BY THE INSURED

1. Name of Insured Person | Certificate No. | Email address

Complete Mailing Address | State | Zip | Date of Birth

Claim is made for: ☐ Self ☐ Spouse ☐ Unmarried Child ☐ Female ☐ Male ☐ Married ☐ Single

(check one) ☐ Unmarried Student attending (Name of School) _____
Is spouse or child covered by their employer? ☐ Yes ☐ No Employer Name_____

4. Name of dependent for whom claim is being made | Date of Birth | ☐ Male ☐ Female

5. Nature of Illness

Date a doctor was seen for this condition | Doctor's Name and **Complete** Address

Was hospital confinement required? ☐ Yes ☐ No | Name of Hospital

Has a doctor been seen for this or a similar condition in the past? ☐ Yes ☐ No Date(s):

Doctor's Name and Address

6. Name and **Complete** Address of Family Doctor

7. If claim is based on an accident:

Was the accident due to injured person's occupation? ☐ Yes ☐ No

Date Occurred | Time | Where did accident occur?

How did accident happen?

8. Is claimant entitled to additional benefits under:

	Yes	No
a. Group Insurance or any other arrangement of coverage for individuals in a group?	☐	☐
b. Blue Cross, Blue Shield or any other prepayment arrangement?	☐	☐
c. Any coverage for students which is sponsored by or provided through a school or other educational institute?	☐	☐
d. Any federal, state, or other governmental program?	☐	☐

If answer to any of above is YES complete the following:

Insured	Name & Address of Insurance company or organization	Policy No.
You		
Spouse		
Child		

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I Hereby authorize payment directly to the undersigned Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for the services as described below but not to exceed the reasonable and customary charge for those services if Certain Underwriters agree to same. ♦

SIGNED (INSURED PERSON)

INTERNATIONAL RISK MANAGEMENT GROUP

13359 Route 413 • Durham Road • PO Box 2104 (18901) • Doylestown, PA 18902
215.794.1488 • FAX 215.794.1498 • 1.888.622.IRMG
www.IRMGroup.com

AUTHORIZATION & 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_____