Send to claims@iatmgu.com
615-790-6908 • www.iatmgu.com

INTERNATIONAL ASSURANCE OF TN
A JENCAP® COMPANY

CATASTROPHIC AND 50% NOTIFICATION

Case:	Policy Period:
EE Name:	EE SSN:
Claimant Name:	DOB:
Relationship:	Original Effective Date on the Plan:
Date Coverage Terminated or Last Date that EE Worked:	
Diagnosis/ICD9:	Prognosis:
Is Claimant in Case Management? ☐ Yes ☐ No If YES, provide Case Manager information below.	
Case Manager's Name:	Case Manager's Phone:
Treating Physician's Name:	Treating Physician's Phone:
Length of Confinement:	Date of Surgery:
Current and Future Treatment:	
PAID TO DATE THIS POLICY YEAR: $	
PENDING CHARGES THIS POLICY YEAR: $	

In lieu of the above information, a Paid Claims Report reflecting diagnosis and provider names can be substituted.

Submitted by: ____________________ Date: ____________

TPA Company Name: ______________________________

Address: ______________________________

Phone: ______________ Ext.: ______ Email: ______________

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