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

INTERNATIONAL ASSURANCE OF TN
A JENCAP® COMPANY

MONTHLY PAID CLAIMS SUMMARY

Case Name:	
Effective Date:	
Month Reporting:	_____ / _____ / _____ to _____ / _____ / _____

PLEASE MAKE SURE THAT ALL MONTHLY PAID CLAIMS ARE REPORTED BY INDIVIDUAL MONTHS

If reporting a 12/15 or 15/12 policy, please specify if run-in claims are included in this total.

GROSS PAID CLAIMS

Medical:	$	
Dental:	$	
Weekly Indemnity:	$	
Rx Drug Card:	$	
TOTAL GROSS PAID CLAIMS:	**$**	0.00
Less Claims Not Covered by Excess:	$	
Net Paid Claims:	**$**	0.00

Additional Comments: _____

_____

_____

Third-Party Administrator: _____

Date: _____ Email: _____

