Record of Household Services

Claim Number

To be completed by person performing service(s): ____________________
(Name)

Address: ____________________ Phone: ____________________

Social Security Number: ____________________ Occupation: ____________________

Relationship to Injured Person: ____________________

First date any service rendered: ____________________

Date of Service	Service Performed	Rate of Pay per Hr / Day / Week (circle one)	Number of Hrs / Days / Weeks Worked (circle one)	Total Charged

Have you been paid for these services? ☐ Yes ☐ No

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Signature ____________________ Date ____________________
(Person performing service)

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(Injured's person signature)