

Claim Date: _____



30 DAY FIT WARRANTY CLAIM FORM

PLEASE RETURN THE OLD FITTINGS WHEN SUBMITTING A WARRANTY CLAIM FORM.

PRIOR TO COMPLETING THIS WARRANTY FORM, CONTACT YOUR REPRESENTATIVE AS AN ON-SITE ADJUSTMENT MAY BE APPLICABLE.

HAVING THESE TO WORK FROM HELPS US AVOID DUPLICATING THE PROBLEM AND PRODUCING A BETTER MATCH WHEN PROCESSING A SINGLE PROTECTOR. IT IS IMPERATIVE THAT WE HAVE YOUR PRESENT FITTINGS TO ALLOW US TO MAKE THE NECESSARY ADJUSTMENTS. SIMPLY PLACE YOUR PROTECTOR FOR WARRANTY INTO A SECURE ENVELOPE AND MAIL DIRECTLY TO CUSTOM PROTECT EAR ATTACHED TO YOUR WARRANTY CLAIM FORM.

(PLEASE PRINT)

NAME: _____
EMPLOYER: _____
PHONE: _____
CONTACT: _____
SHIP TO ADDRESS: _____

D.O. B: _____ YY / MM / DD
SERIAL #: _____
COLOR: _____
STYLE: _____
REPRESENTATIVE: _____

OLD PROTECTORS RETURNED: YES NO
ATTACH TO OLD: LEFT RIGHT

SEAL BREAKS WHEN I: MOVE MY HEAD UP & DOWN SIDE TO SIDE
 TALK OR CHEW (INDICATE WHERE ON DIAGRAMS)

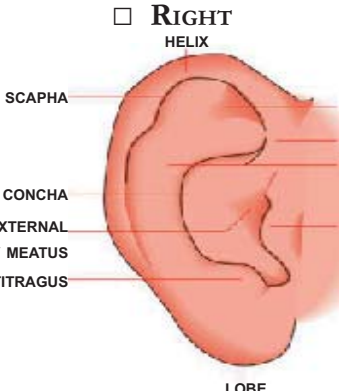
PROTECTORS WILL NOT SEAL AT ALL:

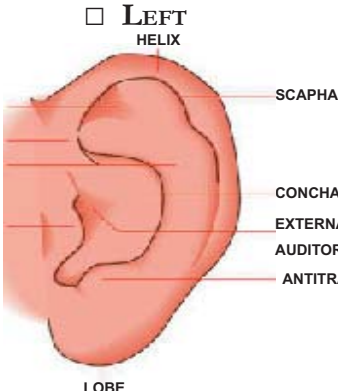
TOP-COATING REQUESTED: (PROVIDES A TIGHTER SEAL)

PROTECTOR IS UNCOMFORTABLE: (PLEASE INDICATE WHERE ON DIAGRAMS)

COMMENTS: _____

THE PROTECTORS HURT MY EAR AT THE: (PLEASE INDICATE WHERE ON DIAGRAMS)

RIGHT
HELIIX


LEFT
HELIIX


NAVICULAR FOSSA
 ROOT OF THE HELIX
 ANTHELIX
 TRAGUS

SOMETIMES EAR PRESSURE CAUSES SYMPTOMS IN OTHER AREAS OF THE BODY. IF WEARING YOUR dB BLOCKERS CAUSES DISCOMFORT IN ANOTHER PART OF YOUR BODY, PLEASE INDICATE BELOW.

LEFT RIGHT

SYMPTOM:

ADDITIONAL INFORMATION: _____

OFFICE USE ONLY	CLAIM #: _____
ORIGINAL DATE: _____	NEW SERIAL #: _____
REVIEW DATE: _____	DISPOSITION: <input type="checkbox"/> REMAKE FROM NEW IMPRESSIONS
REVIEWED BY: _____	<input type="checkbox"/> REPOUR FROM ORIGINAL CAST
S/O #: _____	<input type="checkbox"/> REPAIR <input type="checkbox"/> TOPCOAT
DATE REC'D: _____	<input type="checkbox"/> OTHER: _____
POSTED: _____	SHIPPED: _____