



3900 W. 34th St. N. • Sioux Falls, SD 57107

Main. (605)336-3080
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TSF Claim Initiation Form

The following to be filled out by TSF retail customer:

Date: _____
Claim Initiation Date

Retailer Name: _____ Phone: _____ Fax: _____

Consumer Name: _____ Phone: _____ Fax: _____

Consumer Address: _____
City State Zip

Reason for Complaint: _____

Date of Purchase: _____

TSF Invoice Number: _____

Manufacturer of Product: _____

Description of Product: _____

Instructions: A copy of your original invoice, a sample of the product in question and a copy of your labor bill must be submitted along with this form to initiate a claim. Your claim will not be processed until TSF receives these items.

Retailer Check List:

Claim Initiation Form: _____
Fax or Mail to Don Gaddis (888-336-3043)

Sample of Defective Product: _____

Copy of Original Invoice: _____

Copy of Labor Bill: _____