

Medical Expense Claim

To be completed by claimant

| | | |
|---|----------------|-------------------------|
| Name of Policy holder: | Policy no. | |
| Name of Insured: | Email Address: | |
| Name of Claimant (If other than above): | | Relationship to Insured |
| Address: | | Telephone no. |

1) Does the claimant have medical insurance under any other plan? (Including Spouse's Insurance and/or government health plan).

- NO**
 YES

| | |
|--|------------|
| | Policy no. |
|--|------------|

2) Are any expenses submitted as the result of an accident?

- NO**
 YES

If yes, please provide details, including date and location of accident:

3) Please provide a diagnosis for each bill submitted:

| Date of Service | Charges | Diagnosis/Condition/Illness |
|-----------------|---------|-----------------------------|
| | | |
| | | |
| | | |
| | | |

4) Has the claimant ever had same or similar condition:

- NO**
 YES

If yes, state when and describe: _____

5) How do you wish reimbursement to be made? Cheque Direct Deposit (your bank may impose a service fee) If

Direct Deposit: Name of Bank _____ Bank Number _____
 Branch Address _____ Transit Number _____
 Name of account holder _____ Account Number _____

Please complete this form in its entirety, answering all sections and submit only original bills to the above address.

I authorize the release of any information requested in respect of this claim to the Insurer or its agents and certify that the information given is true, correct and complete to the best of my knowledge.

Signature (Claimant)

Date



Authorization to Disclose Information

Policy No./Certificate No.: _____

I, _____ hereby authorize any hospital, physician, medical practitioner, clinic, other medical or medically related facility, pharmacy, insurance or reinsurance company, Government Agency, Ministry of Health & Long Term Care, to disclose or furnish to **Sutton Special Risk**, its subsidiaries or representatives, any and all information with respect to any illness or injury, medical history, consultations, prescriptions, treatments or benefits, and copies of all applicable records that may be requested. I also authorize my employer to disclose all information needed to process my claim.

The information provided to **Sutton Special Risk**, its subsidiaries or representatives, is to be used solely for the administration of claims(s) as captioned above. The information collected may be exchanged with the above mentioned parties when relevant and necessary for the purposes of assessing this claim. Additional information may be obtained by referring to the Sutton Special Risk privacy policy, which can be found at www.suttonspecialrisk.com or by calling 1-800-461-3292 and asking to speak to the Privacy Officer.

I know that I may request to receive a copy of this Authorization. I agree that a photographic copy of this Authorization shall be as valid as the original. I agree this Authorization shall be valid for two years from the date shown below. I understand that I may withdraw my consent at any time, in writing, subject to legal or contractual restrictions and reasonable notice.

Date (dd/mm/yy)

Claimant's Signature

Claimant Print Name

Date (dd/mm/yy)

Witness Signature

Witness Print Name

Note: A true copy of this Authorization is available to the Claimant or his/her authorized representative at any time, upon request.

Sutton Special Risk
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