SUTTON
SPECIAL RISK

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# 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