SUTTON
SPECIAL RISK

33 Yonge Street, Suite 400
Toronto, Ontario M5E 1G4
Tel: (416) 366-2223
Fax: (416) 366-4608
claims@suttonspecialrisk.com

Medical Expense Claim

To be completed by claimant

Name of Policyholder		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**

Name of Insurer		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) Payee: Employee ☐ Employer ☐

6) How do you wish reimbursement to be made? Cheque ☐ Direct Deposit ☐ Wire Transfer ☐

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

If Wire Transfer:
Name of Bank _____ Bank I.D. (Swift Code) _____
Branch Address _____
Account Number _____ Currency of Account _____
Name of Claimant _____ Account Number (IBAN) _____
Residence Address of Account Holder _____

Signature and Authorization

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