SUTTON
SPECIAL RISK

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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:

____

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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 ☐ 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