SUTTON
SPECIAL RISK

Tel: 416.366.2223
Toll Free: 1.800.461.3292
claims@suttonspecialrisk.com

Proof of Total Disability - Claimant Statement

Please attach: Completed Attending Physician's Statement

A - DETAILS OF ILLNESS

Date and time of Accident Month Day Year ☐ AM ☐ PM	Did accident occur on or off duty? ☐ ON ☐ OFF
Please explain details of accident or illness fully.	
On what date were you first treated by physician?	Onset of Disability
Have you had the same or similar condition previously?	If yes, please provide dates

Have you applied for or are you receiving any disability, wage loss or retirement benefits from a program or plan mentioned below?	NO	IF YES			IF DECLINED	
		Pending	Approved	Declined	Do you Intend to contest the decision? Yes	No
PROGRAM Employment Insurance (EI/HRDC) If approved, start date of benefits: YYYY / MM / DD	❒	☐	☐	☐	☐	☐
Workers' Compensation or similar plan / Commission de la sante et de la securite du travail (WSIB/CSST)	❒	☐	☐	☐	☐	☐
Crime Victims Compensation Act (CVCA)	❒	☐	☐	☐	☐	☐
Automobile Insurance Benefits (AB)	❒	☐	☐	☐	☐	☐
PLAN Canada Pension Plan (CPP) or Quebec Pension Plan (QPP)	❒	☐	☐	☐	☐	☐
Commission administrative de regimes de retraite et d'assurances (CARRA)	❒	☐	☐	☐	☐	☐
Retirement / Pension Plan	❒	☐	☐	☐	☐	☐
Any other disability benefits:	❒	☐	☐	☐	☐	☐

NOTE: PLEASE ENCLOSE A COPY OF ALL DOCUMENTS RECEIVED FROM THESE ORGANIZATIONS, INCLUDING ANY NOTICE OF PAYMENT OF BENEFITS

Names and address of all attending physicians?

Return Completed Forms to Sutton Special Risk
33 Yonge St., Suite 270 Box 311
Toronto, ON M5E 1G4

B - INSURED'S DECLARATION

Employer Name		Policy Number	
Last Name		First Name	
Address of Employee- No., street, apt.	City	Province	Postal Code
Home Tel. No.	Email	Gender ❒ M ❒ F	
Effective Date of Coverage (YYYY/MM/DD)		Date of Birth (YYYY/MM/DD)	

C - AUTHORIZATION

I hereby certify that the above statements made by me are complete, true and correctly recorded.

Claimant Signature Witness Date

Authorization To Obtain Information

I AUTHORIZE any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsuring company, the Medical Information Bureau, consumer reporting agency, or employer having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me, my spouse or my eligible children to give Sutton Special Risk, or its legal representative any and all such information pursuant to this claim. I UNDERSTAND the information obtained by use of this Authorization will be used by Sutton Special Risk, to determine eligibility for coverage or eligibility for benefits under existing coverage. Any information obtained will not be released by Sutton Special Risk, to any person or organization except to the Insurer, or other persons or organizations performing business or legal services in connection with my application, or as may be otherwise lawfully required, or as I may further authorize. 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.

Claimant Signature Witness Date