103, 8411, 200th Street
Langley, BC V2Y0E7
TEL: (604)888-0050
Toll free: 1(800)993 6388
FAX: (604)888-1008
International Fax: 001(604)888-1008
E-mail: claims@SRIM.ca

NOTIFICATION OF CLAIM

Name of Policy Holder _____ Policy No. _____

Name of Insured _____ Male/Female _____ Date of Birth D/M/Y _____

Name of Claimant (If other than above) _____ Relationship to Insured (if applicable) _____

If a Minor, give Full Name of Parent or Guardian (Relationship)
_____

Address _____ City _____ Postal Code _____ Province/ State _____ Country _____

Date of Loss (Note all drug receipts must show patient name, drug name and drug identification number (DIN). If other medical or paramedical receipts should show provider name and address, all dates of visits and detailed related costs. Attach physician referral.

_____

Explain, in detail; How the loss occurred?

_____

_____

_____

Nature of Injury
_____

Name of Dentist or Doctor
_____

Address _____ Apt. _____ City _____ Province _____ Postal Code _____

Does the Claimant have medical insurance under any other plan?
(Including Spouse's insurance/government health plan) _____

Name of Insuring Agency _____

Please complete this form in its entirety, answering all sections and submit original bills to the above address. If you are in a location where there is a delay in submitting original bills, then please scan and e-mail or fax the bills to the above and forward the originals as soon as you are able.

Special Risk Insurance Managers Ltd.

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 to the best of my knowledge

_____

Signature of Claimant or Guardian Date