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.

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

SPECIAL RISK
INSURANCE MANAGERS

CLAIM NO: _____

INSURED: _____

NAME: _____

OTHER INSURANCE DECLARATION FORM

The Policy as purchased by your employer provides coverage in excess of any private or government medical/dental plan. **If you incur medical or dental expense as the result of your loss, you are required to first submit those expenses to your government or private medical dental plan. Only expenses not covered by MSP (the provincial plan for province you reside in) will be considered. Any primary coverage you have in excess of the provincial plan must also be utilized first.**

If in the event your personal medical/dental plan does not provide full reimbursement, you are then eligible to submit the amounts *not paid* to your employer for processing.

Please clarify your situation by checking on of the following:

☐ Yes, I do have private coverage but I do not believe that they will provide full reimbursement and would ask that you keep my claim open until we receive clarification of the amount of the expenses not covered by them, at which time I will forward the amount not covered by them to you for your consideration.

☐ No, I do not maintain any private medical/dental coverage. The expenses I am submitting are not covered by any other primary plan.

If you are a minor, then your parents or legal guardian must complete this form on your behalf.

DATE: _____

NAME: _____
(Please Print)

SIGNATURE: _____

THIS FORM IS TO BE SUBMITTED WITH EVERY CLAIM FORM, DULY COMPLETED AND SIGNED.