SPECIAL RISK
INSURANCE MANAGERS

Suite 103, 8411 – 200th Street, Langley BC, V2Y 0E7
Tel. 604 455 2099 | Toll Free 800 993 6388 | Email: claims@srim.ca
Fax 604 888 1008 | Intl. Fax 001 604 888 1008 | www.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 _____

Telephone Number _____ Date of Loss _____

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? Name of Insuring Agency
(Including Spouse's insurance/government health plan)

_____ _____

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

Received

_____

Signature of Claimant or Guardian Date