SUTTON
SPECIAL RISK

33 Yonge Street, Suite 400
Toronto, Ontario M5E 1G4
Tel: (416) 366-2223
Fax: (416) 366-4608
Toll Free: 800-461-3292

DENTIST STATEMENT OF CLAIM

Insured Information

☐ DENTIST'S PRE-TREATMENT ESTIMATE
☐ DENTIST'S STATEMENT OF ACTUAL SERVICES

Name of Policyholder	Policy no.	Class (if applicable)
Name of Insured	Email Address	
Name of Patient (If other than above)	Relationship to Insured	
Address	Telephone no.	
Is patient covered by another plan? ☐ NO ☐ YES	If yes, state dental plan name, group no. and name and address of carrier.	

Dentist Information

Dentist's Name, Address, and Phone No.							
First visit date for current series	Place of Treatment	Office	Hosp	ECF	Other	Radiographs or model enclosed? ☐ NO ☐ YES	How many?
Is treatment result of occupational illness or injury? ☐ NO ☐ YES	If yes, enter brief description and dates						
Is treatment result of an auto accident or other accident? ☐ NO ☐ YES	If yes, enter brief description and dates						
If prosthesis, is this an initial placement? ☐ NO ☐ YES	If no, reason for replacement and date of prior placement						
Is treatment for orthodontics? ☐ NO ☐ YES	Enter date of initial placement and months of treatment remaining						

Date	Tooth No.	Surface	Description Of Service Including X-Rays, Prophylaxis, materials used etc. Line No.	Procedure No.	Fee	For admin use
				Total Fee Submitted		

I hereby certify that the procedures as indicated by date have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

Signed (Dentist) Date

Reimbursement

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 Athorization

I have reviewed the following treatment plan and I authorize release of any information relating to this claim. I understand that I am responsible for all costs of dental treatment.

Signature (Patient or parent if minor) Date

I hereby assign my benefits payable from this claim to the named Dentist and authorize payment directly to him/her.

Signature (Insured Person) Date

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 400 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

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

Proof of Total Disability - Physician's Statement

Please complete in block letters and give to the patient. The insured must pay the fees requested to complete this form.

A - STATEMENT

Employee Name	Policy Number
Telephone Number	Date of Birth (YYYY/MM/DD)

Mental Condition
Is the patient competent to endorse cheque and direct the use of the proceeds thereof?

B - DIAGNOSIS

Primary

Secondary

Complications

For the illnesses or associated symptoms diagnosed, has the patient previously:

☐ received medical treatments ☐ consulted another physician ☐ taken drugs ☐ been hospitalized ☐ undergone examinations

Specify the periods: _____

Is the disability related to:

☐ an accident ☐ an illness ☐ an occupational accident ☐ an automobile accident

Date of the event (YYYY/MM/DD) _____

Describe the functional limitations that prevent the patient from carrying out professional duties or usual activities

At the beginning of the disability (YYYY/MM/DD): _____	Currently:

C - TREATMENT

Drugs - name - dosage: _____

Has the patient undergone or will undergo:

a) examinations or tests ☐Yes ☐No Specify: _____

b) surgery ☐Yes ☐No Day Surgery ☐ Type: _____

Surgical procedure: _____ Date (YYYY/MM/DD): _____

c) other treatments ☐Yes ☐No

d) hospitalization: From _____ To _____ Name of hospital: _____

e) a short stay under observation ☐Yes ☐No Number of hours: _____

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D - FOLLOW-UP AND PROGNOSIS

Date of first consultation for this disability (YYYY/MM/DD): _____ Next consultation: _____

Date of other consultations (YYYY/MM/DD): _____ Follow-up frequency: _____

Referral to another physician: ❒Yes ❒No Name of Physician: _____

Specialty: _____

Approximate duration of disability: No. of days: _____ No. of weeks: _____ Unspecified❒ or date of return to work (YYYY/MM/DD): _____

How long before the patient will be able to return to work: No. of days: _____ No. of weeks: _____

❒Part-time ❒Full-time ❒Gradual return Specify: _____

E - ADDITIONAL INFORMATION

F - IDENTIFICATION OF THE PHYSICIAN

Family name, given name: _____

License number: _____ Telephone: _____ Fax: _____

❒General Practitioner ❒Specialist Specify: _____

Signature Date (YYYY/MM/DD)

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Proof of Total Disability - Employer Statement

Please attach: Photocopy of employee enrollment card as proof of enrollment

A - IDENTIFICATION

Name of Policyholder or Employer			Policy Number
Amount of Insurance $		Amount of Claim $	
First and Last Name of Employee			Social Insurance Number
Employee Telephone No.	Fax No.	Email	
Address of Employee - No., Street, Apt.	City	Province	Postal Code
Employer Telephone No.	Fax No.	Email	
Effective Date of Coverage (YYYY/MM/DD)		Class No.	

B - GENERAL INFORMATION

Current Salary ❒ Weekly ❒ Monthly ❒ Every Two Weeks	Amount $	Salary Effective Date (YYYY/MM/DD)		Job Status ❒ Full Time ❒ Part Time
Indicate Days in Normal Work Week ❒ SUN ❒ MON ❒ TUES ❒ WED ❒ THU ❒ FRI ❒ SAT	Hours Worked Per Week	Premium Paid by ❒ Employer ❒ Both ❒ Employee	Date of Employment (YYYY/MM/DD)	Occupation
Date Last Worked (YYYY/MM/DD)	Reason for Last Date Worked			

Is disability due to an accident? ❒ Yes ❒ No If "Yes", date of accident: (YYYY/MM/DD)

Did or will the employee receive any income during the disability period? ❒ Yes ❒ No If "Yes", indicate below:
(type: Holiday pay, maternity, disability, EI benefits, salary, lump sum, other)

Type: Amount: $ Period:

Has a claim been filed with a government agency? ❒ Yes ❒ No If "Yes", indicate below:

❒ CSST/WCB/WSIB/WHSCC ❒ CPP/QPP ❒ SAAQ (Quebec only) ❒ No Fault (outside Quebec only)

❒ Other, specify: _____
(YYYY/MM/DD)

Date Filed: Date Rendered: Amount: $

Has the employee returned to work? ❒ Yes ❒ No If "Yes", on what date? (YYYY/MM/DD)

Is this person still in your employ? ❒ Yes ❒ No If "No", specify termination date _____ Reason:
(YYYY/MM/DD)

Was this person given a record of employment? ❒ Yes ❒ No	Are there any work related factors that may have contributed to the employee's disability or had an impact on their return-to-work? ❒ Yes ❒ No If "Yes", please specify:

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C - PHYSICAL WORK ENVIONMENT

Please attach a brief job description if available.

What are the main duties of the employee's job and how much time is allocated to each one weekly?

Duties	%	Duties	%
Duties	%	Duties	%

For the next two questions, FREQUENCY is defined as follows:

OCCASIONALLY: 0-15% of the times **FREQUENTLY: 16-50% of the time** **ALWAYS: 51% + of the time**

Does the employee's job require work in any of the following conditions?

Frequency:	O	F	A	Frequency:	O	F	A	Frequency:	O	F	A
Outside	☐	☐	☐	In a damp or humid environment	☐	☐	☐	Above or below ground level	☐	☐	☐
In extremes of cold or heat	☐	☐	☐	Toxic fume	☐	☐	☐	Handling chemicals	☐	☐	☐

Does the job involve other hazards? ☐Yes ☐No If "Yes", please list: _____

Check the items below that relate to the employee's job, and complete the information requested.

Frequency:	O	F	A	Frequency:	O	F	A	Frequency:	O	F	A
☐ Standing	☐	☐	☐	☐ Bending over	☐	☐	☐	☐ Extending/reaching above head	☐	☐	☐
☐ Walking	☐	☐	☐	☐ Kneeling	☐	☐	☐	☐ Climbing	☐	☐	☐
☐ Sitting	☐	☐	☐	☐ Crouching	☐	☐	☐	☐ Stairs (No. of steps____)	☐	☐	☐
☐ Keeping one's balance	☐	☐	☐	☐ Crawling	☐	☐	☐	☐ Ladders (Height_____)	☐	☐	☐

Describe Activity and Specify Frequency and Weight:	O	F	A	Weight:
☐Pushing _____	☐	☐	☐	☐Lb☐Kg
☐Pulling _____	☐	☐	☐	☐Lb☐Kg
☐Lifting/Carrying _____	☐	☐	☐	☐Lb☐Kg

Please list any office equipment, motor vehicle, tools or other equipment that is used in the employee's job.

Type of Equipment	Times per day
Type of Equipment	Times per day

Does the employee work in an extremely noisy environment, have to work at a fast pace, do repetitice movements or have short deadlines? ☐Yes ☐No

If "Yes", please specify: _____

Does the employee's job require dexterity? ☐Yes ☐No

If "Yes", please specify: _____

D - ADDITIONAL INFORMATION

E - SIGNATURE OF THE AUTHORIZED PERSON

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

Printed Name Position

Signature Date (YYYY/MM/DD)

SUTTON
SPECIAL RISK

Attending Physician's Statement
(Specialist only)

Phone: 416.366.2223
Toll Free: 1.800.461.3292

Dismemberment

Name of Policyholder	Policy no.

PLEASE PRINT

Name of patient: _____ _____
Last Name First Name Date of Birth (mm/dd/yyyy)

1. Please provide a brief outline of the medical history leading to your patient's loss of or loss of use of limbs.

_____

_____

_____

2. When did your patient first consult you for this condition? (mm/dd/yyyy) _____

3. When did the accident occur (mm/dd/yyyy)

_____

4. Please describe the following:
   a) Which limbs are affected? _____
   b) Level at which severance occurred for the affected limbs.

   _____
   c) The underlying cause of this condition. _____

5. Is the loss of limbs permanent?

_____

_____

_____

6. Please give the names and addresses of other physicians consulted or hospitals attended by your patient for this condition.

Name of Physician or Hospital	**Address** (number, street, city, province, postal code)	**Date From** (mm/dd/yyyy)	**Date To** (mm/dd/yyyy)

PLEASE SEE OVER

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

9. Please provide any other information that would be helpful in the assessment of your patient's claim.

10. Please provide results of all relevant investigations and copies of any specialist or hospital reports.

Authorization

Name (please print)	Specialty		
Street Address	City	Province	Postal Code
Area Code & Telephone Number	Fax number		
Date (mm/dd/yyyy)	Signature		

This form is to be completed by a physician licensed in Canada whose practice is limited to the particular branch of medicine relating to the applicable critical illness. The **Insured Person** is responsible for the completion of this form without expense to the Company.

PERSONAL INFORMATION CONSENT: The information collected on this application for insurance is required for the purposes of considering and, if approved, processing this application for insurance. It may also be used to administer the insurance policy, investigate any claims that may be made under this policy, and for the provision of products and services. This information, and information in existing files, may be used by and exchanged among certain underwriters at Lloyds, London, Sutton Special Risk, their agents, affiliates, partners, subsidiaries, reinsurers and authorized administrators for these purposes, regardless of whether a policy is issued or coverage ceases to be in force. Subject to legal and contractual requirements, the applicant may refuse to consent to the collection, use, or disclosure of their personal information for specific purposes by contacting privacyofficer@suttonspecialrisk.com or by calling 1-800-461-3292 and asking to speak to the privacy officer.

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Suite 400 Box 311
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M5E 1G4
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Fax: (416) 366-4608
www.suttonspecialrisk.com

PROOF OF DISMEMBERMENT

Employer's Statement

Please attach: Photocopy of employee enrollment card or proof of enrollment.

Certificate Holder			
Date Coverage Commenced (Month/Day/Year)			
Amount of Insurance $		Amount of Claim $	
Dated at	this	day	20

Signature Official Position Contact email or telephone no.

Claimant's Statement

Please attach completed Attending Physician's Statement

Details of Accident (if applicable)

Date and time of Accident Month Day Year	Did accident occur on or off duty? ☐ YES ☐ NO
Please explain details of accident fully.	
On what date were you first treated by a physician? (Month/Day/Year)	
Provide Names and addresses of all treating physicians	
Provide claimant name, address, telephone and email details	

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

Employee 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.

Employee Signature Witness Date

Submit Claims to SUTTON SPECIAL RISK
33 Yonge Street, Suite 270 Box 311
Toronto, Ontario M5E 1G4
Tel: (416) 366-2223 Fax: (416) 366-4608
Email: claims@suttonspecialrisk.com

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www.suttonspecialrisk.com

PROOF OF DEATH

Employer's Statement

Please attach: Photocopy of employee enrollment card or proof of enrollment.

Certificate Holder	
Date Coverage Commenced	
Amount of Insurance $	Amount of Claim $
Dated at this	day 20

Signature | Official Position | Contact email or telephone no.

Claimant's Statement

Please attach certified copy of Death Certificate

Details of Accident (if applicable)

Date and time of Accident Month Day Year	Did accident occur on or off duty? ○ YES ○ NO
Please explain details of accident fully. Please attach Police report or Coroners Report if Available	
Name of Beneficiary: Relationship to Insured: Benefit(s) Claimed:	
Dependent Claim (to be completed by employee) Full Name _____ DOB_____ Relationship to Insured_____ mm/dd/yyyy	
Was the deceased entirely dependent upon you? Yes___ No___	

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

Beneficiary 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.

Beneficiary Signature | Witness | Date

SUTTON
SPECIAL RISK

Attending Physician's Statement
(Specialist only)

Phone: 416.366.2223
Toll Free: 1.800.461.3292

DEATH

A - DECEASED INFORMATION

Last Name	First Name	Date of Birth (YYYY/MM/DD)

B - PHYSICIAN'S STATEMENT

Date of Death (YYYY/MM/DD)	Place of Death

Residence at Death - No., Street	City	Province	Postal Code

If the deceased died in a hospital or in another institution, please provide the name:

1. Disease of condition directly leading to death (This does not mean the mode of dying, such as heard failure, asthenia, etc. It means the disease, injury or complication which caused death):	Interval between onset and death
2. Antecedent causes (morbid conditions, if any, giving rise to the above condition) due to or as a consequence of: a)	
b)	
3. (a) Other significant conditions (contributing to the death but not related to the disease or condition causing death):	

b) Was death related to acquired immunodeficiency syndrome? ☐ yes ☐ no

4. Date of first attendance in last illness	5. Date of first attendance in last illness	6. Date of diagnosis	7. When was the deceased informed the first time about this illness?

8. Was the death due to: ☐ accident ☐ suicide ☐ homicide Describe briefly:

9. Was an inquest held? ☐ Yes ☐ No If yes, by whom and what findings:

10. Was an autopsy held? ☐ Yes ☐ No If yes, by whom and what findings:

11. Have you treated or advised the deceased during the last 3 years, prior to last illness? ☐ Yes ☐ No
If yes, please provide details:

Nature of Illness or Injury	Name of Physician or Hospital	Address (number, street, city, province, postal code)	Date (mm/dd/yyyy)

12. Did the deceased, to your knowledge, receive treatment during the last 3 years of his life from any other physician, or in any hospital or institution? ☐ Yes ☐ No
If yes, please provide details:

Nature of Illness or Injury	Name of Physician or Hospital	Address (number, street, city, province, postal code)	Date (mm/dd/yyyy)

13. Did the deceased ever use tobacco under any form? ☐ Yes ☐ No	14. When did the deceased start smoking?	15. When did the deceased stop smoking?
16. Specify non-smoking periods:		

C - PHYSICIAN'S INFORMATION

Last Name	First Name	Phone Number
License Number		Fax Number
☐ General Practitioner ☐ Specialist	Specify:	
Signature		Date

This form is to be completed by a physician licensed in Canada whose practice is limited to the particular branch of medicine relating to the applicable critical illness. The **Insured Person** is responsible for the completion of this form without expense to the Company. PERSONAL INFORMATION CONSENT: The information collected on this application for insurance is required for the purposes of considering and, if approved, processing this application for insurance. It may also be used to administer the insurance policy, investigate any claims that may be made under this policy, and for the provision of products and services. This information, and information in existing files, may be used by and exchanged among certain underwriters at Lloyds, London, Sutton Special Risk, their agents, affiliates, partners, subsidiaries, reinsurers and authorized administrators for these purposes, regardless of whether a policy is issued or coverage ceases to be in force. Subject to legal and contractual requirements, the applicant may refuse to consent to the collection, use, or disclosure of their personal information for specific purposes by contacting privacyofficer@suttonspecialrisk.com or by calling 1-800-461-3292 and asking to speak to the privacy officer.

SUTTON
SPECIAL RISK

Authorization to Disclose Information

Policy No./Certificate No.:_____

I,_____ hereby authorize any hospital, physician, medical practitioner, clinic, other medical or medically related facility, pharmacy, insurance or reinsurance company, Government Agency, Ministry of Health & Long Term Care, to disclose or furnish to **Sutton Special Risk**, its subsidiaries or representatives, any and all information with respect to any illness or injury, medical history, consultations, prescriptions, treatments or benefits, and copies of all applicable records that may be requested. I also authorize my employer to disclose all information needed to process my claim.

The information provided to **Sutton Special Risk**, its subsidiaries or representatives, is to be used solely for the administration of claims(s) as captioned above. The information collected may be exchanged with the above mentioned parties when relevant and necessary for the purposes of assessing this claim. Additional information may be obtained by referring to the Sutton Special Risk privacy policy, which can be found at www.suttonspecialrisk.com or by calling 1-800-461-3292 and asking to speak to the Privacy Officer.

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. I understand that I may withdraw my consent at any time, in writing, subject to legal or contractual restrictions and reasonable notice.

_____	_____	_____
Date (dd/mm/yy)	Claimant's Signature	Claimant Print Name
_____	_____	_____
Date (dd/mm/yy)	Witness Signature	Witness Print Name

Note: A true copy of this Authorization is available to the Claimant or his/her authorized representative at any time, upon request.

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