SUTTON
SPECIAL RISK

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(416) 366-2223
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Proof of Dismemberment

Employer's Statement

Please attach photocopy of employee enrollment card or proof of enrollment.

Name of Policyholder	Policy no.
Effective Date of Coverage (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

Date and time of Accident Month Day Year	Did the accident occur while on the duties of your occupation? ☐ YES ☐ NO
Please provide details of accident.	
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