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**MEDICAL EXPENSE
 CLAIM FORM**

TO BE COMPLETED
 BY CLAIMANT

Name of Policyholder:	Policy no.
Name of Insured:	
Name of Claimant (if other than above)	Relationship to Insured
Address:	Telephone no.

1) Does the claimant have medical insurance under any other plan? (Including Spouse's insurance and/or government health plan).

NO
 YES

Name of Insuring Agency	Policy no.
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2) Are any expenses submitted as the result of an accident?

NO
 YES

If yes, please provide details, including date and location of accident:

3) Please provide a diagnosis for each bill submitted:

Date of Service	Charges	Diagnosis/Condition/Illness

4) Has the claimant ever had same or similar condition:

YES
 NO

State when and describe:

Please complete this form in its entirety, answering all sections and submit only original bills to the above address. We are unable to process copied bills.

WILLIAM J. SUTTON & CO. 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 and complete to the best of my knowledge.

Signature (Claimant)

Date