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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.

SC International Insurance Consultants Ltd. – a division of Sports- Can Insurance

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