SUTTON
SPECIAL RISK

33 Yonge Street
Suite 400 Box 311
Toronto, Ontario
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(416) 366-2223
Fax: (416) 366-4608
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