

REQUEST FOR REIMBURSEMENT - SPECIFIC CLAIM

Insured: _____
Claimant: _____ Your File No.: _____
D/Occurrence: _____ SNCC File No.: _____

REIMBURSEMENT OF INDEMNITY, MEDICAL & EXPENSE PAYMENTS

INDEMNITY PAID TO DATE: \$ _____
MEDICAL PAID TO DATE: \$ _____
EXPENSES PAID TO DATE: \$ _____
TOTAL AMOUNT PAID TO DATE: \$ _____
Minus SELF-INSURED RETENTION: -\$ _____
PAID AMOUNT IN EXCESS OF S.I.R.: \$ _____
Minus PRIOR REIMBURSEMENTS: -\$ _____
TOTAL INDEMNITY, MEDICAL & EXPENSES REQUESTED: \$ _____

Payment summary and detail printout must be attached to process reimbursement

TOTAL AMOUNT REQUESTED = \$ _____

SWORN STATEMENT IN PROOF OF LOSS

The undersigned, as the designated representative for the above Named Insured, states that the above figures are true and correct. Any statements attached hereto are made part of this instrument.

By: _____ Date: _____

PLEASE PRINT OR TYPE: **This form completed as of** _____
Name: _____
Company: _____
Address: _____
City/State/Zip: _____
Phone Number: _____