

# REQUEST FOR REIMBURSEMENT - SPECIFIC CLAIM

Insured: \_\_\_\_\_  
Claimant: \_\_\_\_\_ Your File No.: \_\_\_\_\_  
D/Occurrence: \_\_\_\_\_ SNCC File No.: \_\_\_\_\_

## ***REIMBURSEMENT OF INDEMNITY & MEDICAL PAYMENTS***

INDEMNITY PAID TO DATE: \$ \_\_\_\_\_  
MEDICAL 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 REQUESTED: \$ \_\_\_\_\_ (a)

***Payment summary and detail printout must be attached to process reimbursement***

## ***REIMBURSEMENT OF ALLOCATED EXPENSES***

Allocated expenses, which include legal fees, are not reimbursed in the same manner as indemnity and medical payments. Per the contract, expenses are reimbursed on a pro rata basis at the conclusion of the claim.

Safety National's share is computed using the following formula:

|  |   |  |
|--|---|--|
| <u>Paid Amount in Excess of S.I.R.</u> | X | Allocated Expenses = Safety National's share |
| Total Amount Paid on Claim             | X |  |
| (\$ _____ )                            |   | (\$ _____ ) = (\$ _____ ) (b)                |
| _____                                  |   |  |
| (\$ _____ )                            |   |  |

***TOTAL AMOUNT REQUESTED (a) + (b) =***

## **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: \_\_\_\_\_

**Safety National Casualty Corporation**  
1832 Schuetz Road, St. Louis MO 63146  
Telephone (314) 995-5300 Facsimile (314) 995-3897