Proof of Loss for Accident
Centre d'acquisitions gouvernementales
DENTAL CLAIM

SSQ, Life Insurance Company Inc., 1225 St-Charles Street West, Suite 200, Longueuil QC J4K 0B9
claims.spgroup@ssq.ca

1. Statement of Participant

1.1 Policy No.: _____ **1.2 Certificate No.** (if known): _____

1.3 Participant Name: _____ 1.4 Date of Birth: Y Y Y Y M M D D
First Name Last Name

1.5 Is the Injured Person a Canadian resident? ☐ Yes ☐ No

1.6 If Injured Person is a minor, give Full Name of Parent/Guardian: _____

1.7 Address: _____ Postal Code: _____
Street City Province

1.8 Email (of parent if minor): _____

1.9 Name of the School Board and District: _____

1.10 **Accident Description**

a) Date of the accident: Y Y Y Y M M D D b) Place of accident: _____

c) Describe injury: _____

d) Describe fully how accident occurred: _____

_____

1.11 **Health Treatment**

a) Date of first treatment: Y Y Y Y M M D D b) Date treated in hospital: Y Y Y Y M M D D

c) Full Name of Physician: _____ Telephone: _____

d) Name of Hospital if applicable: _____

1.12 Do you have any other Hospital or Medical Insurance? ☐ Yes ☐ No

Plan Name/Policy Number: _____

I agree that the information provided on this form is complete and accurate. I understand that the information provided by me to SSQ, Life Insurance Company Inc. about myself and my dependents, will be used by SSQ, Life Insurance Company Inc. for claims adjudication and any other services necessary in the administration of our benefits which may include the exchange of information with other parties to administer this benefit claim. I authorize release of the information contained in this claim form to my insuring company / plan administrator. I am authorized by my spouse and/or dependent children affected by this claim to disclose and receive information about them.

_____ Y Y Y Y M M D D _____
Signature of Participant (Parent or Guardian if injured member is a minor) Date Telephone

2. Direct Deposit

Please provide the following information if you would like your claim payment deposited to a bank account. **Please attach a "Void" cheque.**

_____ _____ _____
Bank # Transit # Account #

3. School Declaration

3.1. Name of School: _____

3.2. Complete Address: _____ Postal Code: _____
Street City Province

3.3. Name of Administrator: _____ 3.4. Official Position: _____

3.5. Effective date of Student's coverage: Y Y Y Y M M D D 3.6. Policy No.: _____

3.7. Was the student injured during an approved activity? ☐ Yes ☐ No

_____ Y Y Y Y M M D D _____
School Official Signature Date Telephone

4. Dentist

4.1 Unique No. _____ 4.2 Spéc. : _____ 4.3 Patient's Office Account Number _____

4.4

Patient's Name	Dentist's Name
Address	Address
Telephone	Telephone

For Dentist use only ☐ Duplicate form
(for additional information, diagnosis, procedures or special consideration)

Date of Service	Procedure Code	Intl. Tooth Code	Tooth Surfaces	Dentist's Fees	Laboratory Charges	**Total Charges**
Y Y Y Y | M M | D D						
Y Y Y Y | M M | D D						
Y Y Y Y | M M | D D						
Y Y Y Y | M M | D D						
Y Y Y Y | M M | D D						
Y Y Y Y | M M | D D						
Y Y Y Y | M M | D D						
Y Y Y Y | M M | D D						
This is an accurate statement of services performed and the total fee due and payable, E & OE.				**Total Fee Submitted :** $ _____		

5. Dentist's Supplementary Report

5.1. Description of damage? _____

5.2. Is further treatment indicated? ☐ Yes ☐ No If Yes, please indicate :

Int. Tooth Code	Treatment Indicated – use procedure code if possible	Estimated Date – Treatment
		Y Y Y Y | M M | D D
		Y Y Y Y | M M | D D
		Y Y Y Y | M M | D D
		Y Y Y Y | M M | D D

5.3. Describe further potential problems and indicate time frame? _____

5.4. a) How many teeth were injured? _____ b) Were these whole or sound teeth? ☐ Yes ☐ No

c) How many of these teeth had fillings? _____ d) How many of these injured teeth had crowns? _____

e) How many of these injured teeth had root canal treatment? _____

f) If not whole or sound teeth, explain reason why _____

_____ Y Y Y Y \| M M \| D D

Dentist's Signature Date

6. Remit Payment to Provider (To be completed by the employee if cheque is to be made payable to the Provider)

I hereby assign to _____ any benefits payable from this claim to the named dentist and authorize payment directly to him/her, but not to exceed the charge for the services described on this claim form.

I understand that the fees listed in this claim may not be covered by or may exceed my plan benefits. I understand that I am financially responsible to my dentist for the entire treatment. I acknowledge that the total fee of $ _____ is accurate and has been charged to me for services rendered.

_____ Y Y Y Y \| M M \| D D _____

Signature of patient (or parent / guardian) Date Telephone