Confirmation of accident-related loss
Centre d'acquisitions gouvernementales – HEALTHCARE

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

1. Participant's statement

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

1.3. Insured person's name: ______________ (First name) ______________ (Last name) 1.4 Date of birth: Y Y Y Y M M D D

1.5 If a minor, first and last name of a parent or legal guardian: ______________

1.6. Mailing address: (or of parent/legal guardian if minor) ______________ Street ______________ City ______________ Province Postal code

1.7 Insured person's email address (or of parent/legal guardian if minor): ______________

1.8 **Description of the accident**

a) Date of the accident: Y Y Y Y M M D D b) Location of the accident: ______________

c) Describe the injury: ______________

d) Provide detailed description of how the accident occurred: ______________

1.9 **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: ______________

1.10 **IMPORTANT** – Please indicate if you are covered by another insurance plan: ☐ Yes ☐ No

Plan name/Policy No.: ______________

Signature (parent or legal guardian if minor) ______________

I consent to have any information or file required for the purpose of this application disclosed to the insurer or plan administrator. I declare that the information provided is true, accurate and complete to the best of my knowledge. I understand that the information I have provided will be used by SSQ, Life Insurance Company Inc. for the administration of my benefits and may be shared with other parties solely for the purpose of settling this claim. I am authorized by my spouse or my dependents impacted by this form to disclose and receive information regarding them. I accept to have all communications pertaining to my claim sent to me by email.

Participant's signature (parent or legal guardian if minor) ______________ Date Y Y Y Y M M D D Telephone ______________

2. Mandatory application for direct deposit

Complete the following information to have the paid benefits deposited in a bank account in Canada. **Enclose a cheque specimen marked "VOID".**

Bank No. ______________ Transit No. ______________ Account No. ______________

3. School declaration

3.1. Name of school: ______________

3.2. Complete address: ______________ Street ______________ City ______________ Province Postal code

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

School official's signature ______________ Date Y Y Y Y M M D D Telephone ______________

4. Attending physician's initial statement

(**IMPORTANT**: It is not necessary to have the attending physician's declaration completed again for subsequent expenses related to an ongoing claim, if you are only claiming ambulance expenses or expenses under $100)

4.1. Patient's name: ____________________ 4.2. Date of birth: Y Y Y Y M M D D

4.3. Diagnosis of current condition: ____________________

a) Primary: ____________________

b) Secondary (if any): ____________________

4.4. Examination date: Y Y Y Y M M D D | Y Y Y Y M M D D | Y Y Y Y M M D D

4.5. To your knowledge:

a) What is the date of the accident or the onset of symptoms? Y Y Y Y M M D D

b) Has the patient had a similar condition before? ☐ Yes ☐ No

If so, provide the date and specify: ____________________

4.6. Hospital name, if applicable: ____________________

Admitted on: Y Y Y Y M M D D Time: ________ Discharged on: Y Y Y Y M M D D Time: ________

4.7. Nature of the operation, if applicable:

____

4.8. Name of the referring physician: ____________________

4.9. Referral of patient to a specialist: ☐ Yes ☐ No

If so, specify: ____________________

4.10. Referral of patient for physiotherapy: ☐ Yes ☐ No If so, provide the date: Y Y Y Y M M D D

Duration and frequency of treatment:

____

4.11. To your knowledge, what was or will be the duration of the patient's total disability (unable to attend school)?

From Y Y Y Y M M D D To Y Y Y Y M M D D inclusively

4.12. If still disabled, when will the patient be able to resume classes? Y Y Y Y M M D D

If uncertain, how much longer does the patient need? ________ additional weeks

What was or will be the duration of the patient's partial disability (attending school part-time)?

From Y Y Y Y M M D D To Y Y Y Y M M D D inclusively

Name of physician (in capitals letters): ____________________

Licence number: ________ ☐ General practitioner ☐ Specialist Specify ____________________

Address: ____________________ Postal code

Street City Province

Telephone: ____________ Fax: ____________

____________________ Y Y Y Y M M D D

Signature Date

5. Dentist's supplementary report (In the case of accidental injury to natural teeth)

5.1. Description of damage: ______________________________

____

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

Int. Tooth Code	Required treatment – Use procedure code if possible	Estimated date of treatments
		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 damaged: ________

b) Were these whole and sound teeth? ☐ Yes ☐ No

c) How many of these teeth had fillings? ________

d) How many of these damaged teeth had crowns? ________

e) How many of these damaged teeth had root canal treatment? ________

f) If not whole and sound teeth, explain reason why: ______________________________

Dentist's name (in capital letters): ______________________________

Licence number: ____________

Address: ______________________________ Postal code

Street City Province

Telephone: ____________ Fax: ____________

______________________________ Y Y Y Y M M D D

Dentist's signature Date

6. Payment to provider

I hereby **cede** to ______________________________ the benefits payable under this claim, the amount of which cannot exceed the expenses identified on the form, and I consent to them being paid directly.

It is possible that the expenses indicated on this claim may not be covered by my plan or may only be partially covered. It is therefore my responsibility to ensure that my dentist is paid for all the services rendered. I acknowledge that the total fee amounts to $____________, that this amount is accurate and that this amount was invoiced to me for the services received. I consent to having all the information in this claim disclosed to the Insurer or plan administrator.

______________________________ Y Y Y Y M M D D ____________

Insured person's signature (parent or legal guardian if minor) Date Telephone

It is the patient's responsibility to have this form completed and to pay the corresponding fee.