SSQ Financial Group

Emergency medical claim report
OUT-OF-PROVINCE / OUT-OF-COUNTRY

SSQ, Insurance Company Inc. · 1200 Papineau Avenue, Suite 460 · Montreal (QC) · H2K 4R5
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1. Statement of Participant

1.1 **Policy No.**: _____ 1.2 **Certificat 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 participant retired? ☐ Yes ☐ No

1.6 Address: _____ _____ _____ _____
Street City Province/Country Postal Code

1.7 Email: _____

To be completed by the Participant who is claiming for his/her dependent children. (Please complete one claim form per child).

1.8 Dependent Name | Relationship to Participant | Date of Birth (Y Y Y Y M M D D)

Claimant Signature (if over 18 years old): _____

1.9 Does he/she permanently reside with you? ☐ Yes ☐ No Is your dependent child married? ☐ Yes ☐ No

Is he/she in attendance at University or College? ☐ Yes ☐ No

If "Yes", give name and address of school.

_____

1.10 Is the claimant insured under a provincial health plan? ☐ Yes ☐ No If "No", please provide an explanation.

_____

1.11 Does the claimant have any other health insurance? ☐ Yes ☐ No If "Yes", please give name and address of company.

_____

Policy Number: _____ Type of Coverage: _____

1.12 Employer's Name: _____ 10. Telephone No.: _____

1.13 Employer's Address: _____

2. Authorization

I agree that the information provided on this form is complete and accurate. I understand that the information provided by me to SSQ about myself and my dependents, will be used by SSQ 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 Date Telephone Number

3. Direct deposit

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

_____ _____ _____
Bank # Transit # Account #

4. Claim Details

4.1 Was this expense incurred while travelling on business? ☐ Yes ☐ No

4.2 Departure date from province: Y Y Y Y M M D D 4.3 Return date to province: Y Y Y Y M M D D

4.4 This claim is due to: ☐ Injury ☐ Sickness Describe how and where it happened:

4.5 When did injury occur or symptoms of sickness first appear? Y Y Y Y M M D D

4.6 Where did injury occur or symptoms of sickness were first noted (city/country)? _____

4.7 Have you had same or similar condition before? ☐ Yes ☐ No If yes, when? _____

If "Yes", provide details.

4.8 Were you hospitalized for your present condition? ☐ Yes ☐ No If "Yes", please provide the following:

Name and address of hospital: _____

Dates of hospital confinement:

From Y Y Y Y M M D D to Y Y Y Y M M D D | From Y Y Y Y M M D D to Y Y Y Y M M D D

4.9 Name and address of your family doctor in Canada.

Name: _____ Telephone: _____

Address: _____

5. Schedule of Expenses (if space is insufficient, please continue on a separate sheet of paper)

Important – Send original copy of receipts or invoice (Keep copies for personal records. Originals will not be returned.)

Date of Service	Claimed services	Name of Provider	Total Bill*	Country and Currency	Has Account Been Paid? Yes	Has Account Been Paid? No	Paid By Provincial Health Plan	Paid by Other Insurance Carrier
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					☐	☐		
Y Y Y Y M M D D					☐	☐		
		Totals						

6. Remit payment to provider (To be completed by the participant if cheque is to be made payable to the Provider)

I hereby assign to _____ benefits payable to me, but not to exceed the charge for the services described on this claim form. I understand that I am financially responsible for charges not covered by this assignment. I certify to the best of my knowledge that the statements made are true, correct and complete.

Signature of Participant | Date Y Y Y Y M M D D | Telephone Number