EMERGENCY MEDICAL CLAIM REPORT
OUT-OF-PROVINCE / OUT-OF-COUNTRY

SSQ, Insurance Company Inc.
1225 St-Charles Street West, Suite 200 • Longueuil (QC) • J4K 0B9
Fax : 1-855-690-9895 • **Email: claims.spgroup@ssq.ca**

1. Statement of Participant

(to be completed in full by the Claimant)

1.1 **Policy No.:** 1C910 1.2 **Certificate No.:** (if known) .....

1.3 Participant Name ..... (First Name) ..... (Last Name) 1.4 Date of Birth D M Y

1.5 Is the participant retired? ☐ Yes ☐ No

1.6 Address ..... (Street) ..... (City) ..... (Province/Country) ..... (Postal Code)

1.7 Email .....

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

1.8 Dependent Name ..... Relationship to Participant ..... Date of Birth D M Y

Claimant's 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 ..... 1.13 Telephone No. ( )

1.14 Employer's Address .....

2. Direct deposit

Please provide the following information if you would like your claim payment deposited to a **Canadian** bank account:

Bank # ..... Transit # ..... Account # ..... **Please attach a "Void" cheque**

3. 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.

..... D M Y ( )

Signature of Participant Date Telephone Number

4. Claim Details

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

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

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? D M Y

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", 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 D M Y to D M Y From D M Y to D M Y

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

6. Authorization

I declare the above information to be complete and accurate. I understand that the information I have provided will be used by SSQ, Insurance Compagny to adjudicate my claims and that it may be shared with third parties only for the purpose of allowing them to process this claim. I am authorized by my spouse and/or dependent children affected by this claim to disclose and receive information about them.

Signature of Participant D M Y Date ( ) Telephone Number