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.:** 1JM45 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

SSQ Financial Group

CONSENT TO COLLECT, USE AND DISCLOSE PERSONAL INFORMATION
(ACCIDENT AND SICKNESS CLAIMS)

I authorize SSQ Insurance Company Inc. and its authorized representatives to collect, use, and disclose personal information about me and, where applicable, my dependent children as permitted by law from and to the following persons and organizations:

- any licensed medical practitioner or licensed health professional, hospital, clinic or medically related facility;
- any other insurance company or financial institution, including any reinsurance company;
- any other person or organization with information relevant to my claim; and
- any person or organization that provides information services or insurance services to, or that acts as insurance intermediary for SSQ Insurance Company Inc.;

for the following purposes:

- establishing and maintaining communications with me;
- underwriting group risks on a prudent basis;
- investigating and settling claims;
- detecting and preventing fraud;
- offering and providing products and services to meet my needs;
- compiling insurance statistics; and
- complying with the law.

The personal information collected by SSQ Insurance Company Inc. will be entered into a file whose subject is accident and sickness insurance. The file will be kept at SSQ Insurance Company Inc. offices. Within SSQ Insurance Company Inc., this file will only be accessed by those employees who require access in order to fulfill the purposes listed above. I understand that I may access my personal information contained in this file and correct such information if necessary by directing a written request to:

Privacy Officer
SSQ Insurance Company Inc.
1200 Papineau Avenue
Suite 460
Montreal, Quebec H2K 4R5

This consent shall be valid for the length of time necessary for SSQ Insurance Company Inc. to achieve the purposes listed above. I may withdraw this consent at any time by giving SSQ Insurance Company Inc. written notice of withdrawal. I understand that withdrawal of my consent might result in SSQ Insurance Company Inc. being unable to provide me with a product or service.

A copy of this consent shall be considered as effective and valid as the original.

POLICY NO.	

DATE OF THE OCCURENCE DD / MM / YYYY	CAUSE (ACCIDENT, ILLNESS, ETC.)
SIGNATURE OF INSURED X	DATE OF SIGNATURE DD / MM / YYYY
PRINT NAME OF INSURED	TELEPHONE NUMBER
ADDRESS	

Where the claim is for the Accidental Death of the Insured Person, this consent must be signed by their authorized representative, and shall apply to both the Insured Person and the authorized representative:

SIGNATURE OF AUTHORIZED REPRESENTATIVE X	DATE OF SIGNATURE DD / MM / YYYY
PRINT NAME OF AUTHORIZED REPRESENTATIVE	RELATIONSHIP TO THE INSURED

The completed authorization can be returned to SSQ Insurance Company Inc. at any of the following addresses:

SSQ Place, 110 Sheppard Avenue East, Suite 500, Toronto, Ontario M2N 6Y8
1200 Papineau Avenue, 4th floor, Montreal QC H2K 4R5
800 – 6th Avenue S.W., Suite 650, Calgary, Alberta T2P 3G3