Confirmation of accident-related loss
Accident insurance for students attending university in Quebec

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 Mailing address: _____ Postal Code _____
Street City Province

1.6 Insured's email address: _____

1.7 **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: _____

_____

1.8 **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: _____

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

Plan Name/Policy Number: _____

Signature _____

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 accept to have all communications pertaining to my claim sent to me by email.

_____ Y Y Y Y M M D D _____
Signature of Participant Date 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: _____ 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. 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 Doctor (in capitals letters): _____

License 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 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: _____

Dentist's name (in capital letters): _____

License Number: _____

Address: _____ Postal Code _____
Street City Province

Telephone: _____ Fax: _____

_____ Y Y Y Y M M D D
Dentist 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's signature Date Telephone

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