Proof of Loss for Accident
STUDENT INSURANCE – HEALTH CLAIM

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.: 1PU20 **1.2 Certificate No.** (if known): _____

1.3 Participant Name: _____ 1.4 Date of Birth: A A A A M M J J
First Name Last Name

1.5 Is the Injured Person a Canadian resident? ☐ Yes ☐ No

1.6 If Injured Person is a minor, give Full Name of Parent/Guardian: _____

1.7 Address: _____ Postal Code: _____
Street City Province

1.8 Email (of parent if minor): _____

1.9 Name of the School Board and District: _____

1.10 **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: _____

1.11 **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: _____

1.12 Do you have any other Hospital or Medical Insurance? ☐ Yes ☐ No

Plan Name/Policy Number: _____

I agree that the information provided on this form is complete and accurate. I understand that the information provided by me to SSQ, Life Insurance Company Inc. about myself and my dependents, will be used by SSQ, Life Insurance Company Inc. 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 (Parent or Guardian if injured member is a minor) Date Telephone

2. Direct Deposit

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

_____ _____ _____
Bank # Transit # Account #

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 Statement Section

4.1. Patient's Name: _____ 4.2. Patient's Date of Birth: Y Y Y Y M M D D

4.3. Diagnosis of present condition: _____

a) Primary: _____

b) Secondary (if applicable): _____

4.4. On what dates did you examine the patient? 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 the best of my knowledge:

a) Symptoms first appeared or accident happened? Y Y Y Y M M D D

b) Patient has had same or similar condition? ☐ Yes ☐ No

If "Yes", state particulars: _____

_____

4.6. If attended at hospital, name of hospital: _____

Admitted: Y Y Y Y M M D D Time: _____ Discharged: Y Y Y Y M M D D Time: _____

4.7. If surgery performed, describe: _____

_____

4.8. If patient referred to you, give name of referring physician: _____

4.9. Have you referred the patient to a specialist for additional treatments ☐ Yes ☐ No

If "Yes", please explain: _____

_____

4.10. Have you referred the patient for physiotherapy treatments? ☐ Yes ☐ No If yes, date such referral was made: Y Y Y Y M M D D

Frequency and duration of physiotherapy treatments? _____

4.11. To the best of my knowledge, the patient has been totally disabled (unabled to attend school)

From Y Y Y Y M M D D to Y Y Y Y M M D D inclusive

4.12. If still disabled, what date should the patient be able to return to school? Y Y Y Y M M D D

Or, if indefinite, what is the estimated number of weeks before such return _____ additional weeks.

How long was or will the patient be partially disabled (able to attend part-time school)?

From Y Y Y Y M M D D to Y Y Y Y M M D D inclusive

Physician's Name (Print): _____

License Number: _____ ☐ General Practitioner ☐ Specialist Specify: _____

Address: _____ Postal Code: _____

Street City Province

Telephone: _____ Fax: _____

_____ Y Y Y Y M M D D

Signature Date

The patient is responsible for securing this form and for any charges made for its completion.