PROOF OF LOSS FOR ACCIDENT

STUDENT INSURANCE – HEALTH CLAIM

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. CLAIMANT'S STATEMENT

4.1. **Policy No.** ..... 4.2. **Certificate No.** (if known) .....

4.3. Insured Name .... 4.4. Date of Birth D M Y .....
Given Name Family Name

4.5. Is the Injured Person a Canadian resident? ☐ Yes ☐ No

4.6. If Injured Person is a minor, give Full Name of Parent/Guardian .....

4.7. Address .....
Street City Province Postal Code

4.8. Email (of parent if minor) .....

4.9. Name of the School Board and District .....

4.10. Date of the accident D M Y 4.11. Place of accident .....

4.12. Describe injury .....

4.13. Describe fully how accident occurred .....

.....

.....

4.14. Date of first treatment D M Y 4.15. Date treated in hospital D M Y

4.16. Full Name of Physician ..... Telephone No. ( )

4.17. Name of Hospital if applicable .....

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

Plan Name/Policy Number .....

I certify to the best of my knowledge that the statements made above are true, correct and complete. 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.

..... D M Y ( )
Insured Person's 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 **Canadian** bank account:

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

3. SCHOOL DECLARATION

3.1. Name of School .....

3.2. Complete Address .....
Street City Province Postal Code

3.3. Name of Administrator ..... 3.4. Official Position .....

3.5. Effective date of Student's coverage D M Y 3.6. Policy No. .....

3.7. Was the student injured during an approved activity? ☐ Yes ☐ No

..... D M Y ( )
School Official Signature Date Telephone

4. ATTENDING PHYSICIAN STATEMENT SECTION

Policy No.

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

4.3. Diagnosis of present condition _____

(a) Primary _____

(b) Secondary (if applicable) _____

4.4. On what dates did you examine the patient? D M Y | D M Y | D M Y

4.5. To the best of my knowledge

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

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

If "Yes", state particulars _____

4.6. If attended at hospital, name of hospital _____

Admitted D M Y Time _____ AM/PM

Discharged D M Y Time _____ AM/PM

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: D M Y

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 D M Y to D M Y inclusive

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

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 D M Y to D M Y inclusive

Physician's Name (Print) _____

License Number _____ ☐ General Practitioner ☐ Specialist Specify : _____

Address _____
Street City Province Postal Code

Telephone ( ) Fax : ( )

_____ D M Y

Physician's Signature Date

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