SSQ Financial Group

Emergency medical claim report
OUT-OF-PROVINCE / OUT-OF-COUNTRY

SSSQ Financial Group, 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 **Certificat 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 Is the participant retired? ☐ Yes ☐ No

1.6 Address: ______________ ______________ ______________ ______________
Street City Province/Country Postal Code

1.7 Email: ______________

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

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

Claimant 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.

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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: ______________ 10. Telephone No.: ______________

1.13 Employer's Address: ______________

2. Authorization

I agree that the information provided on this form is complete and accurate. I understand that the information provided by me to SSQ about myself and my dependents, will be used by SSQ 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 of Participant Date Telephone Number

3. Direct deposit

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

______________ ______________ ______________
Bank # Transit # Account #

4. Claim Details

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

4.2 Departure date from province: Y Y Y Y | M M | D D   4.3 Return date to province: Y Y Y Y | M M | D D

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? Y Y Y Y | M M | D D

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, when? ______________________________

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 Y Y Y Y | M M | D D to Y Y Y Y | M M | D D | From Y Y Y Y | M M | D D to Y Y Y Y | M M | D D

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	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
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					☐	☐		
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					☐	☐		
Y Y Y Y | M M | D D					☐	☐		
		Totals						

6. 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.

______________________________ Y Y Y Y | M M | D D ______________________________

Signature of Participant   Date   Telephone Number