SSQ Financial Group

HEALTH INSURANCE BENEFIT CLAIM

P.O. Box 10500, station Sainte-Foy, Quebec QC G1V 4H6
P.O. Box #5, Suite 400, 1550-5th Street SW, Calgary (Alberta) T2R 1K3

SECTION 1 - PARTICIPANT INFORMATION

Group No. | **SSQ Certificate No.**

Last Name | **First Name**

Address

Town/City | **Province** | **Postal Code**

SECTION 2 - DECLARATION

I declare that all attached expenses have been incurred for : ☐ Myself ☐ My spouse ☐ My dependent children (indicated below)
Is this the first declaration for any of these individuals? ☐ No ☐ Yes, complete section 3
Are these expenses covered under another insurance contract? ☐ No ☐ Yes, complete section 4
Are these expenses the result of an accident? ☐ No ☐ Yes, complete section 5

SECTION 3 - TO BE COMPLETED IF IT IS THE FIRST CLAIM FOR YOUR SPOUSE OR YOUR DEPENDENT CHILDREN

Last Name	First Name	Date of birth (YYYY-MM-DD)	Gender	Relationship with participant
			☐ F ☐ M	☐ Spouse ☐ Dependent child *
			☐ F ☐ M	☐ Spouse ☐ Dependent child *
			☐ F ☐ M	☐ Spouse ☐ Dependent child *

* If your child is unmarried, aged under 26 in accordance with your contract and a full-time student, you must fill out a declaration of school attendance for him or her to remain eligible for insurance benefits as a dependent child. Visit our website at www.ssq.ca under ACCESS | Plan Members.

SECTION 4 - TO BE COMPLETED IF YOU HAVE SIMILAR HEALTH INSURANCE COVERAGE WITH ANOTHER INSURER

Name of policyholder ____________ Name of other insurer ____________ Contract Number ____________

Coverage status : Family ☐ Individual ☐ Single-Parent ☐ Couple ☐

Benefit type : Drug ☐ Dental Care ☐ Visual Care ☐ Others ☐

SECTION 5 - TO BE COMPLETED IF THE EXPENSES ARE THE RESULT OF AN ACCIDENT

Name of injured individual : ____________
Accident date (YYYY-MM-DD) : ______/______/______
Accident type: ☐ **work** ☐ **automobile** ☐ **other** ____________

SECTION 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, Life Insurance Company Inc. 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.

Participant signature: ____________ **Date :** ______/______/______

IMPORTANT

- **Send original copies of receipts or invoices and keep copies for your personal records. Originals will not be returned.**
- **If your claim is for services from a healthcare professional (chiropractor, physiotherapist, etc.), make sure the receipt or invoice clearly states the name of the patient, the date, nature and fees for each treatment and the name of the healthcare professional, the association he or she is a member of and his or her license number.**
- **Make sure to organize receipts or invoices per patient.**