

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.

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.

Signature of Participant _____ Date | Y | Y | Y | Y | | M | M | D | D | 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: 4.3 Return date to province:

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?

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 to | From to

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?		Paid By Provincial Health Plan	Paid by Other Insurance Carrier
					Yes	No		
<input type="text" value="Y Y Y Y M M D D"/>					<input type="checkbox"/>	<input type="checkbox"/>		
<input type="text" value="Y Y Y Y M M D D"/>					<input type="checkbox"/>	<input type="checkbox"/>		
<input type="text" value="Y Y Y Y M M D D"/>					<input type="checkbox"/>	<input type="checkbox"/>		
<input type="text" value="Y Y Y Y M M D D"/>					<input type="checkbox"/>	<input type="checkbox"/>		
<input type="text" value="Y Y Y Y M M D D"/>					<input type="checkbox"/>	<input type="checkbox"/>		
<input type="text" value="Y Y Y Y M M D D"/>					<input type="checkbox"/>	<input type="checkbox"/>		
<input type="text" value="Y Y Y Y M M D D"/>					<input type="checkbox"/>	<input type="checkbox"/>		
<input type="text" value="Y Y Y Y M M D D"/>					<input type="checkbox"/>	<input type="checkbox"/>		
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.

Signature of Participant

Date

Telephone Number