EMERGENCY MEDICAL CLAIM REPORT
OUT OF CANADA

SSQ Insurance Company Inc.
1200 Papineau Avenue, 4th floor, Montreal QC H2K 4R5

Please answer all questions fully – it helps us to provide better service.

Important: In the provinces of Ontario, British Columbia, Alberta, Saskatchewan, New Brunswick and Quebec, claims can be submitted directly to SSQ Insurance Company Inc. In all other provinces claims must be supported by a copy of the details of the claimant's provincial health plan and other insurance carriers' settlement or denial, and a copy of all ORIGINAL bills showing the date and details of services rendered.

It is important that all questions on this claim report be answered - if any section is not applicable indicate by n/a.

Note: This form can be completed in ink (please print), however, the form must be signed and dated and then the ORIGINAL, signed form in its entirety along with ORIGINAL medical receipts must be returned to **SSQ Insurance Company Inc.** at the following address:

1200 Papineau Avenue, 4th floor, Montreal QC H2K 4R5

Emailed, faxed or photocopied forms (once completed) are unacceptable for claims purposes.

Insured Information

1. **Insured Person's Full Name** _____ 2. Date of Birth D M Y _____
3. Policy Number _____ 4. Employee Number _____
5. **Claimant's Name** _____ 6. Relationship to Insured _____
7. Claimant's Signature _____ 8. Date of Birth D M Y _____
9. *To be completed by Insured Employee who is claiming for his/her dependent children. (Please complete one claim form per child)*
   Is your dependent child married? ☐ Yes ☐ No Does he/she permanently reside with you? ☐ Yes ☐ No
   Is he/she in attendance at University or College? ☐ Yes ☐ No If "Yes", give name and address of school
   _____
10. Employer's Name _____ 11. Telephone No. ( ) _____
12. Employer's Address _____

Claim Details

1. Was this expense incurred while travelling on business? ☐ Yes ☐ No
2. Departure date from province D M Y _____ 3. Return date to province D M Y _____
4. This claim is due to ☐ Injury ☐ Sickness (Describe how and where it happened)
   _____
   _____
   _____
5. When did injury occur or symptoms of sickness first appear? D M Y _____
6. Where did injury occur or symptoms of sickness were first noted (city/country)? _____
7. (a) Have you had same or similar condition before? ☐ Yes ☐ No If "Yes", provide details
   _____
   _____
   _____

(b) Please provide names of physicians consulted for your previous condition

Name _____ Address _____

Diagnosis _____ Consulted: From/To _____

Name _____ Address _____

Diagnosis _____ Consulted: From/To _____

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

9. Name and address of your family doctor in Canada

Name _____ Telephone ( )

Address _____

10. Is the claimant insured under a provincial health plan? ☐ Yes ☐ No - If "No", please provide an explanation

_____

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 _____

Schedule of Expenses

(if space is insufficient, please continue on a separate sheet of paper)

Has Account Been Paid? **Yes**	**No**	Name of Provider	Date of Service (D/M/Y)	Total Bill*	Do Not Write in This Space	Do Not Write in This Space	Paid By Provincial Health Plan	Paid by Other Insurance Carrier	Do Not Write in This Space
☐	☐								
☐	☐								
☐	☐								
☐	☐								
☐	☐								
☐	☐								
☐	☐								
☐	☐								
☐	☐								
☐	☐								
			Totals						

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

Insured's Signature _____ Date D M Y

Permanent Address _____ Telephone No. ( )

Mailing Address _____ Telephone No. ( )

Please return completed claim form with the "Consent to collect, use and disclose personal information" form.