HEALTH INSURANCE BENEFIT CLAIM FORM

This form must be used for health claims (drugs, health care professionals, vision care, etc.)

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

SSQ Certificate No.

Last Name	**First Name**
Address	

Town/City **Province** **Postal Code** **Telephone Number**

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 between 18 and 26 in accordance to 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 Member or contact your employer.

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.**