SSQ Financial Group

PROOF OF LOSS - ACCIDENTAL DENTAL
SPORTS INSURANCE

SSQ Insurance Company Inc.
1225 St-Charles Street West, Suite 200, Longueuil QC J4K 0B9

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

Instructions - Insured member - complete Claimant's Statement; Team Manager or Administrator -complete Club Section at bottom of page 1. Attending Dentist - complete Dental Section on page 2.
Important - If the member is covered under any other Extended Health or Dental insurance plan, the expenses must be submitted to the Extended Health plan (Accidental Dental Benefit) and then to the Dental plan. If there is any unpaid balance, please attached their payment statement(s).

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

1225 St-Charles Street West, Suite 200, Longueuil QC J4K 0B9
claims.spgroup@ssq.ca
Fax: 1-855-690-9895

Claimant's Statement

Policy Number **1PA25**

1. Insured Member's Full Name ______ 2. Date of Birth D M Y
3. If a minor, give full name of parent or guardian ______
4. Date of Accident D M Y 5. Where did accident occur? ______
6. Describe in detail how accident occurred ______
7. Where was practice or game taking place? ______
8. Date first treated by dentist D M Y
9. Name of Dentist ______
   Address ______
   Number & Street City Province Postal Code
10. Name(s) of other dentist(s) who treated you ______ ______ ______
11. If treated in hospital, Name of Hospital ______ 12. Date treated D M Y
13. Do you have coverage for any dental expenses under any other Hospital, Medical or Dental Plan? ☐ Yes ☐ No
    If Yes, Plan Name ______ Company ______ Policy Number ______
    If Yes, claim must be submitted to your other insurance first and their reply sent to us with this claim form.

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

Claimant's Signature (or signature of Parent or Guardian if Claimant is a minor) ______ Telephone Number ( ) ______ Date D M Y

Complete Address ______
Number & Street City Province Postal Code

Email: ______

The furnishing of this form or its acceptance is not an admission of liability by the company or a waiver of any conditions of the policy.

Sport Body Authorization

Policy Number **1PA25**

What sport is team engaged in? ______

Was the player injured doing an approved activity? ☐ Yes ☐ No If Yes, an approved ☐ practice ☐ game ☐ travelling

Authorized Signature ______ Print Name ______ Official Position/Title ______

Complete Address ______
Number & Street City Province Postal Code

Telephone Number ( ) ______ Date D M Y

Proof of Loss – Accidental Dental (Sports Insurance)

Part 1 – Dentist

Policy No.: 1PA25

Unique No. | Spec. | Patient's Office Account Number

Patient's Name

Address

Telephone No: ( )

Dentist's Name

Address

Telephone No: ( )

I hereby assign any benefits payable from this claim to the named dentist and authorize payment directly to him/her.

Signature of Subscriber

For Dentist use only (for additional information, diagnosis, procedures or special consideration)

☐ Duplicate form

I understand that the fees listed in this claim may not be covered by or may exceed my plan benefits. I understand that I am financially responsible to my dentist for the entire treatment. I acknowledge that the total fee of $ .... is accurate and has been charged to me for services rendered. I authorize release of the information contained in this claim form to my insuring company / plan administrator.

Signature of patient (parent / guardian)

☐ Office Verification

Date of Service (D/M/Y)	Procedure Code	Intl. Tooth Code	Tooth Surfaces	Dentist's Fees	Laboratory Charges	**Total Charges**	For Carrier Use : Allowed Amount	Inc.	%	Patient's Share
							Cheque No.		Date (D/M/Y)	
							Deductible	Patient Pays	Plan Pays	

This is an accurate statement of services performed and the total fee due and payable, E & OE.

Total Fee Submitted : **$**

Claim Number

Part 2 – Dentist's Supplementary Report

1. Description of damage

2. Is further treatment indicated? ☐ Yes ☐ No If **Yes**, please indicate :

Int. Tooth Code	Treatment Indicated – use procedure code if possible	Estimated Date – Treatment (D/M/Y)

3. Describe further potential problems and indicate time frame.

4. A) How many teeth were injured? B) Were these whole or sound teeth? ☐ Yes ☐ No C) How many of these teeth had fillings?
   D) How many of these injured teeth had crowns? E) How many of these injured teeth had root canal treatment?
   F) If not whole or sound teeth, explain reason why

Dentist's Signature Licence Number: Date D M Y