SSQ Financial Group

PROGRAMME D'ASSURANCE POUR LES ATHLÈTES CANADIENS · PAAC · CAIP · CANADIAN ATHLETE INSURANCE PROGRAM

EMERGENCY MEDICAL CLAIM REPORT
OUT OF PROVINCE / OUT OF COUNTRY

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

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:

1225 St-Charles Street West, Suite 200, Longueuil QC J4K 0B9 or claims.spgroup@ssq.ca

Insured Information

1. **Insured Person's Full Name** ____________________ 2. Date of Birth D ___ M ___ Y ___
3. Policy Number ____________________
4. **Person's Name claiming for the insured** ____________________
5. Signature ____________________ 6. Date of Birth D ___ M ___ Y ___
7. *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
   ____
8. Name of Sport Body ____________________ 9. Telephone No. ( ) ____________________
10. Address ____________________
11. Sport Body Email: ____________________

Claim Details

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

Emergency Medical Claim Report: Out-of-Province / Out-of-Country (continued)

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

Name ______________ Address ______________

Diagnosis ______________ Consulted: From/To ______________

Name ______________ Address ______________

Diagnosis ______________ Consulted: From/To ______________

7. 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

8. Name and address of your family doctor in Canada

   Name ______________ Telephone ( )

Address ______________

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

   ____

10. 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. ( )

Email: ______________

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