PROOF OF LOSS
ACCIDENTAL MEDICAL
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: Injured Member complete Insured Statement Section; Team Manager or Administrator complete Club Section at bottom of page 1. Attending Physician complete Physician Statement Section on page 2.

Important: If Injury involves teeth, please complete Accidental Dental Claim Form. If the Member is covered under any other Medical insurance plan, the expenses must be submitted to that plan. If there is any unpaid balance, please attach their Payment Statement. Please retain copies of receipts for your files, as originals will not be returned.

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 along with ORIGINAL medical receipts 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

Insured Statement Section

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. What is your occupation outside of your sports activities? .....
5. Employer .....
   Address .....
   Street City Province Postal Code
6. Type of Sport .....
7. Date first treated by doctor or physical therapist D M Y .....
8. Describe injury .....
9. Describe fully how accident occurred and confirm date of accident .....
10. Full Name of Physician or Physical therapist who first treated you .....
    Address .....
    Street City Province Postal Code
11. Full Name(s) and address(es) of other doctor(s) who treated you .....
12. Name of hospital if treated in hospital .....
13. Date treated in hospital D M Y .....
14. Do you have any other private Hospital or private Medical Insurance? ☐ Yes ☐ No Plan Name/Policy Number .....
    If yes, claim must be submitted to your other insurance first and their reply sent to us with claim form.

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

..... ( ) ..... D M Y .....
Injured Member's Signature (or Signature of Parent or Guardian if injured member is a minor) Telephone Date

Complete Address .....
Street City Province Postal Code

Email:

Sport Body Authorization

What sport is team engaged in .....

....
Authorized Signature Print Name Official Position/Title

Complete Address .....
Street City Province Postal Code

Telephone ( ) ..... Date D M Y .....

Attending Physician Statement Section

 Policy Number 1PA25

(Please note that a certified Physiotherapist or Athletic therapist may complete this form)

1. Patient's Name _____ 2. Patient's Age _____
3. Diagnosis of present condition _____
   (a) Primary _____
   (b) Secondary (if applicable) _____
4. On what dates did you examine the patient? D M Y _____ D M Y _____ D M Y _____
5. To the best of my knowledge
   (a) Symptoms first appeared or accident happened D M Y _____
   (b) Patient has had same or similar condition? ☐ Yes ☐ No
   If "Yes", state particulars _____
6. If attended at hospital, name of hospital _____
   Admitted D M Y _____ Time _____ AM/PM
   Discharged D M Y _____ Time _____ AM/PM
7. If surgery performed, describe _____
8. If patient referred to you, give name of referring physician _____
9. Have you referred the patient to a specialist for additional treatments? ☐ Yes ☐ No If yes, date such referral was made: D M Y _____
   If "Yes", please describe type of treatments, frequency and duration. _____

Physician's or Therapist Name (Print) _____ Physician's or Therapist Signature _____

Address _____
Street City Province Postal Code

Telephone ( ) _____ Date D M Y _____

The patient is responsible for securing this form and for any charges made for its completion.

***Attending Physician Statement Section**

- This section can be completed, signed and dated by a Registered Physiotherapist or Certified Athletic Therapist, member of the Canadian Athletic Therapists Association (CATA) for treatment for Physiotherapy, Athletic Therapy and / or Massage Therapy only.
- All other insured treatments require a Physician to complete and sign this section.