SSQ Financial Group

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, Bureau 200, Longueuil QC J4K 0B9

Insured Statement Section

Policy Number: .....

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. Name of Team for which you were playing ..... 7. Type of Sport .....
8. Date of Accident D M Y ..... 9. Date first treated by doctor D M Y .....
10. Where did accident occur? .....
11. Was it during an approved ☐ practice ☐ game ☐ travelling If travelling, please provide the following:
    Date of departure from prov. of residence D M Y ..... Date of return to prov. of residence D M Y .....
12. Describe injury .....
13. Describe fully how accident occurred .....
14. Full Name of Physician who first treated you .....
    Address .....
    Street City Province Postal Code
15. Full Name(s) and address(es) of other doctor(s) who treated you .....
16. Name of hospital if treated in hospital .....
17. Date treated in hospital D M Y .....
18. Do you have any other Hospital or Medical Insurance? ☐ Yes ☐ No Plan Name/Policy Number .....

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

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

Club Section

1. Name of Team ..... **2. Policy Number** .....
3. Name of League or Association .....
4. What sport is team engaged in ..... 5. On what date did player join the team D M Y .....
6. Was the above player a regular member at the time of injury ☐ Yes ☐ No
7. Was the player injured during an approved activity? ☐ Yes ☐ No If yes, an approved ☐ practice ☐ game ☐ travelling

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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 .....

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", please explain .....
10. Have you referred the patient for physiotherapy treatments? ☐ Yes ☐ No If yes, date such referral was made: D M Y .....
    Frequency and duration of physiotherapy treatments? .....

Physician's Name (Print) ..... Physician's 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.