SSQ Financial Group

PROOF OF LOSS
ACCIDENTAL MEDICAL
SPORTS INSURANCE

SSQ Insurance Company Inc.
1200 Papineau Avenue, 4th floor, Montreal QC H2K 4R5

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:

1200 Papineau Avenue, 4th floor, Montreal QC H2K 4R5

Emailed, faxed or photocopied forms (once completed) are unacceptable for claims purposes.

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. 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** 1PA25
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

_____ _____ _____
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

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.