Health claim form
FOREIGN NATIONALS IN CANADA / CANADIANS WORKING ABROAD

SSQ, Life Insurance Company Inc., 1225 St-Charles Street West, Suite 200, Longueuil QC J4K 0B9
claims.spgroup@ssq.ca

1. Statement of Participant

1.1 **Policy No.**: _____ 1.2 **Certificate No.** (if known): _____

1.3 Participant Name: _____ _____ 1.4 Date of Birth: Y Y Y Y M M D D
First Name Last Name

1.5 Dependent Full Name (if applicable) | Relationship to Participant | Date of Birth

		Y Y Y Y M M D D
		Y Y Y Y M M D D
		Y Y Y Y M M D D
		Y Y Y Y M M D D

(if space is insufficient, please use a separate sheet of paper)

1.6 Name and address of post-secondary school he/she is currently attending if dependent child is age 21 or older. Please include Proof of Registration/Enrollment

_____

1.7 Complete Address in Canada: _____ _____ _____ _____
Street City Province Postal Code

1.8 Complete Address outside Canada: _____

1.9 Email Address: _____

1.10 If Expatriate – indicate date of departure from place of posting: Y Y Y Y M M D D

Expected date of return to place of posting: Y Y Y Y M M D D

1.11 Are you eligible for benefits under a Provincial Health Plan? ☐ Yes ☐ No

Are your dependents eligible for benefits under a Provincial Health Plan? ☐ Yes ☐ No

Do you have any other medical plan? ☐ Yes ☐ No If "Yes", please complete the following.

Name of eligible family member: _____ Relationship: _____

Name of Insurance Company administering the Plan: _____

Policy Number: _____ Type of insurance: _____

2. Authorization

I agree that the information provided on this form is complete and accurate. I understand that the information provided by me to SSQ, Life Insurance Company Inc. about myself and my dependents, will be used by SSQ, Life Insurance Company Inc. for claims adjudication and any other services necessary in the administration of our benefits which may include the exchange of information with other parties to administer this benefit claim. I authorize release of the information contained in this claim form to my insuring company / plan administrator. I am authorized by my spouse and/or dependent children affected by this claim to disclose and receive information about them.

_____ Y Y Y Y M M D D _____
Signature of Participant Date Telephone Number

3. Health Claim Section

Important – Send original copy of receipts or invoice (Keep copies for personal records. Originals will not be returned.)

First Name of Claimant	Nature of Illness/Injury	Claimed services : Drug name and strength of each prescription (if not for drugs, state the nature of the expense)	Date of Receipt	Cost of each item	Country and Currency
			Y Y Y Y M M D D		
			Y Y Y Y M M D D		
			Y Y Y Y M M D D		
			Y Y Y Y M M D D		
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			Y Y Y Y M M D D		

4. Attending Physician Information

Physician Name: _____ Speciality: _____

Address: _____ _____ _____ _____
Street City Province / Country Postal Code

Telephone: _____ Fax: _____

5. Direct deposit

Please provide the following information if you would like your claim payment deposited to a **Canadian** bank account. Please attach a "Void" cheque.

_____ _____ _____
Bank # Transit # Account #

For a direct deposit in a **foreign currency**, please complete the *Authorization Direct Deposit/ Bank Transfer* form.

6. Remit Payment to Provider (To be completed by the employee if cheque is to be made payable to the Provider)

I hereby assign to _____ benefits payable to me, but not to exceed the charge for the services described on this claim form. I understand that I am financially responsible for charges not covered by this assignment. I certify to the best of my knowledge that the statements made are true, correct and complete.

_____ Y Y Y Y M M D D _____
Signature of Participant Date Telephone Number