INPATRIATE/EXPATRIATE MEDICAL & EXTENDED HEALTH CLAIM FORM

SSQ Insurance Company Inc.

Please answer all questions fully – it helps us to provide better service.

All questions can be completed in ink (please print), however, the form must be signed and dated by ALL parties.
Emailed, faxed or photocopied forms (once completed) are unacceptable for claims purposes.

Instructions to Insured:

1. Complete the Insured's Statement Section and the Extended Health Claim Section on Page 2.
2. Have your Physician complete the Attending Physician Statement Section if the claim is over $500.00.
3. Return the ORIGINAL form, completed and signed, directly to **SSQ Insurance Company Inc.** at any of the following addresses:
   SSQ Place, 110 Sheppard Avenue East, Suite 500, Toronto, Ontario M2N 6Y8
   1200 Papineau Avenue, 4th floor, Montreal QC H2K 4R5
   800 - 6th Avenue S.W., Suite 650, Calgary, Alberta, T2P 3G3
4. Please retain copies of receipts for your files, as originals will not be returned.

Insured's Statement Section

(to be completed in full by the Claimant) **Policy Number:** .....

1. Insured's Full Name ..... Date of Birth D M Y .....
2. Dependent's Full Name (if applicable) | Relationship to Insured/Employee | Date of Birth

   ..... | ..... | D M Y .....

   ..... | ..... | D M Y .....

   (if space is insufficient, please use a separate sheet of paper)
3. 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
4. Complete Address in Canada .....
   Number & Street City Province Postal Code
5. Complete Address outside Canada .....
6. Email Address (if applicable) .....
7. If Expatriate – indicate date of departure from place of posting D M Y .....

   expected date of return to place of posting D M Y .....
8. Are you or your dependents eligible for benefits under a Provincial Health Plan? ☐ Yes ☐ No

   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 Coverage .....
9. Please provide the following information if you would like your claim payment deposited to a **Canadian** bank account:

   Bank # ..... Transit # ..... Account # ..... Please attach a "Void" cheque

Assignment

(To be completed by the employee if cheque is to be made payable to the Provider). This assignment is limited to physicians and hospitals for payment over $500.00.

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.

..... D M Y ..... ( ) .....

Signature of Insured Employee Date Telephone Number

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

Extended Health Claim Section

(to be completed by the Claimant) **Policy Number:** .....

Instructions: All claims must be accompanied by the original receipts, itemized statements or invoices; treatment and diagnosis must be included. Photocopies will not be accepted. If space is insufficient, please use a separate sheet of paper.

Important: Please complete the form in full to avoid delay in processing your claim.

First Name of Claimant	Nature of Illness/Injury	Drug name and strength of each prescription (if not for drugs, state the nature of the expense)	Date of Receipt (D-M-Y)	Cost of each item	Country and Currency	**For Office Use Only** Currency Rate	Canadian Funds

Attending Physician's Section

(to be completed by the Attending Physician)

1. Diagnosis (describe complications, if any) and Procedures

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2. When did the patient first consult you for this condition? D M Y .....

3. To the best of your knowledge, when did the symptoms first appear or accident happen? D M Y .....

4. Has patient ever had same or similar condition? ☐ Yes ☐ No

   If "Yes", approximate date(s) of treatment for such condition D M Y ..... | D M Y ..... | D M Y .....

   State particulars of treatment .....

5. Describe any other disease or infirmity affecting the patient's present condition

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6. Is the condition due to pregnancy? ☐ Yes ☐ No

7. If Yes, what was the approximate date of commencement of pregnancy? D M Y .....

8. Was the patient hospitalized? ☐ Yes ☐ No If Yes, From D M Y ..... To D M Y .....

9. Name and address of hospital .....

10. If an operation was performed, state the nature of the operation .....

11. Date Performed D M Y ..... 12. By Doctor .....

13. Physician's Name (please print) ..... Physician's Signature .....

    Address .....
    Street City Province Postal Code

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

The patient is responsible for securing the Attending Physician's Statement and for any charges made for its completion.