SSQ Financial Group

Notice of Claim
CRITICAL ILLNESS COVERAGE

SSQ, Insurance Company inc.

110 Sheppard Avenue East, Suite 500
Toronto (ON) M2N 6Y8
Fax: 1-866-411-9248

800 - 6th Avenue S.W., Suite 650
Calgary (AB) T2P 3G3
Fax: 1-866-411-9248

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

1. Identification of participant

1.1 Police No.: ____________ **1.2 Certificat No.**: (if known): ____________ 1.3 Effective Date of Coverage: Y Y Y Y M M D D

1.4 Participant Name: ____________ ____________ 1.5 Date of Birth: Y Y Y Y M M D D
First Name Last Name

1.6 Home Address: ____________ ____________ ____________ ____________
Street City Province Postal Code

1.7 Email: ____________

1.8 Occupation: ____________ 1.9 Class/Division: ____________

1.10 Amount of Principal Sum: **Basic:** ____________ **Optional:** ____________ **1.11 Optional Policy No.** (if different): ____________

2. Identification of insured diagnosed with critical illness

☐ Participant (go to question 2.4) ☐ Spouse ☐ Dependent Child

2.1 Insured Name: ____________ ____________ 2.2 Date of Birth: Y Y Y Y M M D D
First Name Last Name

2.3 Address (if different than participant): ____________ ____________ ____________ ____________
Street City Province Postal Code

2.4 Date of Diagnosis: Y Y Y Y M M D D

2.5 Nature of Loss (Cancer, Heart attack, Stroke, etc.): ____________

3. Identification of the employer / Policyholder

3.1 Employer / Policyholder: ____________

3.2 Representative Name: ____________ 3.3 Telephone No.: ____________

3.4 Email: ____________

4. Identification of the person reporting the loss

4.1 First Name and Last Name: ____________

4.2 Relationship to participant: ☐ Employer/Policyholder ☐ Broker ☐ Participant ☐ Beneficiary ☐ Other

4.3 Email: ____________ 4.4 Telephone No.: ____________

4.5 Send claim forms to the attention of: ____________

4.6 Address: ____________

____________ Y Y Y Y M M D D
Signature of the person reporting the loss Date

FAS401A (2016-06)