

## **EMERGENCY MEDICAL CLAIM REPORT**

## OUT-OF-PROVINCE / OUT-OF-COUNTRY

SSQ, Insurance Company Inc. 1225 St-Charles Street West, Suite 200 • Longueuil (QC) • J4K 0B9 Fax: 1-855-690-9895 • Email: claims.spgroup@beneva.ca

1. Statement of Participant	(to be completed in full by the Claimant)										
1.1 Policy No.:  1.2 Certificate No.: (if known)											
1.3 Participant Name	Last Name	1.4 [	Date of Birth D M Y								
1.5 Is the participant retired?											
1.6 Address											
Street	City	Province/Country	Postal Code								
1.7 Email											
To be completed by Participant who is claim	ng for his/her dependent childre	en. (Please complete one cl	aim form per child)								
1.8 Dependent Name	Relat	Date of Birth									
			D M Y								
Claimant's Signature (if over 18 years old)											
1.9 Does he/she permanently reside with your ls he/she in attendance at University or		Is your dependent child If "Yes", give name and									
1.10Is the claimant insured under a provincial health plan?   Yes No - If "No", please provide an explanation											
1.11Does the claimant have any other health	insurance?	- If "Yes", please give na	ame and address of company								
Policy Number	Type of Co	verage									
1.12Employer's Name		1.13Telephone N	lo. ( )								
4.44Emanlayaria Addresa											
2. Direct deposit											
Please provide the following information if	vou would like vour claim paym	ent deposited to a Cana	dian bank account:								
Bank # Transit #	Account #	•	ch a "Void" cheque								
Dank // Handt //	/toodin //		on a voia oneque								
3. Remit payment to provider	(To be completed by the participant if cl	neque is to be made pavable to	the Provider)								
I hereby assign to claim form. I understand that I am finance knowledge that the statements made are true	benefits payable to me, b	ut not to exceed the char	rge for the services described on this								
	D 1	и Y	( )								
Signature of Participant	Date		Telephone Number								

4. Cla	im Details									
4.1. Was	this expense incurre	ed while travelling o	n business?	☐ Yes ☐ No						
4.2. Dep	arture date from prov	rince D	M	Y4	.3. Ret	urn dat	e to province D	M Y		
4.4. This claim is due to ☐ Injury ☐ Sickness (Describe how and where it happened)										
4.5.34//				0 D M		Υ				
	en did injury occur or	•				1				
	<ul> <li>4.6. Where did injury occur or symptoms of sickness were first noted (city/country)?</li> <li>4.7. Have you had same or similar condition before? ☐ Yes ☐ No If "Yes", provide details</li> </ul>									
	_									
4.8. Wer	e you hospitalized fo	r your present cond	lition?	☐ Yes ☐ No	If "Yes	", pleas	se provide the follow	ing:		
Name	and address of hosp	oital:								
D-4										
From	of hospital confinem  D M Y		M Y	From	D	М	Y to D	M Y		
	ne and address of you			FIOIII		1 1 1	10 _5			
Name		aa, a.c				Telep	ohone ( )			
Addre						·				
- 0.										
	nedule of Expen	•	-	ient, please continue						
Importan	t - Send original copy	of receipts or invo	ice (Keep cor	oies for personal re	cords. (		ls will not be returne	d.)		
Date of Service				Country and	Acco Been		Paid By Provincial	Paid by Other		
(D/M/Y)	Claimed services	Name of Provider	Total Bill*	Currency	Yes	No	Health Plan	Insurance Carrier		
		Totals								
	horization									
I declare the above information to be complete and accurate. I understand that the information I have provided will be used by SSQ, Insurance Compagny to adjudicate my claims and that it may be shared with third parties only for the purpose of allowing them to process this claim. I am authorized by my spouse and/or dependent children affected by this claim to disclose and receive information about them.										
				<u>D</u>		M	Υ (	)		
Signature of Participant			Da	ate		Te	elephone Number			