PROOF OF LOSS FOR ACCIDENT

STUDENT INSURANCE – DENTAL CLAIM

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

1. CLAIMANT'S STATEMENT

4.1. **Policy No.** 1PU20 4.2. **Certificate No.** (if known) .....

4.3. Insured Name .... 4.4. Date of Birth D M Y .....
Given Name Family Name

4.5. Is the Injured Person a Canadian resident? ☐ Yes ☐ No

4.6. If Injured Person is a minor, give Full Name of Parent/Guardian .....

4.7. Address .....
Street City Province Postal Code

4.8. Email (of parent if minor) .....

4.9. Name of the School Board and District .....

4.10. Date of the accident D M Y 4.11. Place of accident .....

4.12. Describe injury .....

4.13. Describe fully how accident occurred .....

.....

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4.14. Date of first treatment D M Y 4.15. Date treated in hospital D M Y

4.16. Full Name of Physician ..... Telephone No. ( ) .....

4.17. Name of Hospital if applicable .....

4.18. 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. 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.

..... D M Y ( ) .....
Insured Person's Signature (Parent or Guardian if injured member is a minor) Date Telephone

2. DIRECT DEPOSIT

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**

3. SCHOOL DECLARATION

3.1. Name of School .....

3.2. Complete Address .....
Street City Province Postal Code

3.3. Name of Administrator ..... 3.4. Official Position .....

3.5. Effective date of Student's coverage D M Y 3.6. Policy No. .....

3.7. Was the student injured during an approved activity? ☐ Yes ☐ No

..... D M Y ( ) .....
School Official Signature Date Telephone

4. DENTIST

Policy No.:

Unique No.		Spec.		Patient's Office Account Number	

Patient's Name	**Dentist's Name**	**For Dentist use only** ☐ Duplicate form (for additional information, diagnosis, procedures or special consideration)
Address	**Address**	
Telephone ( )	Telephone ( )	

Date of Service (D/M/Y)	Procedure Code	Intl. Tooth Code	Tooth Surfaces	Dentist's Fees	Laboratory Charges	**Total Charges**

This is an accurate statement of services performed and the total fee due and payable, E & OE.

Total Fee Submitted :
$

5. DENTIST'S SUPPLEMENTARY REPORT

5.1. Description of damage

5.2. Is further treatment indicated? ☐ Yes ☐ No If **Yes**, please indicate :

Int. Tooth Code	Treatment Indicated – use procedure code if possible	Estimated Date – Treatment (D/M/Y)

5.3. Describe further potential problems and indicate time frame.

5.4. A) How many teeth were injured? B) Were these whole or sound teeth? ☐ Yes ☐ No

C) How many of these teeth had fillings? D) How many of these injured teeth had crowns?

E) How many of these injured teeth had root canal treatment?

F) If not whole or sound teeth, explain reason why

Dentist's Signature Date D M Y

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 any benefits payable from this claim to the named dentist and authorize payment directly to him/her, but not to exceed the charge for the services described on this claim form.

I understand that the fees listed in this claim may not be covered by or may exceed my plan benefits. I understand that I am financially responsible to my dentist for the entire treatment. I acknowledge that the total fee of $ is accurate and has been charged to me for services rendered.

Signature of patient (or parent / guardian) D M Y Date ( ) Telephone