Your Family or Single-Parent group insurance contract provides insurance coverage for any child with a disability, regardless of age, provided the child is:

1. an unmarried child of the participant;
2. living at home with a parent or legal guardian;
3. afflicted with a prolonged and severe mental or physical disability of indefinite duration (this person must not be receiving benefits under the last resort financial assistance program set out in the *Act respecting income support, employment assistance and social solidarity*); and
4. incapable of pursuing regular gainful employment, due to the disability.

If the child was a student at the time the disability occurred, please enclose a declaration of school attendance from the school attended at that time.

PLEASE RETURN THIS DOCUMENT TO SSQ AT YOUR EARLIEST CONVENIENCE

PARTICIPANT'S DECLARATION

TO BE COMPLETED BY THE PARTICIPANT

CHILD

Last Name _____ First Name _____

Date of Birth: Y _____ M _____ D _____

Gender: M ☐ F ☐ Student Yes ☐ No ☐ If yes, attach a declaration of school attendance.

PARTICIPANT

Last Name _____ First Name _____

Complete Address _____

Telephone No. _____ Contract No. _____

Select all that apply

I certify that the aforementioned child is:

☐ my (and/or my spouse's) child;

☐ unmarried;

☐ entirely dependent on me for support;

☐ receiving social assistance;

☐ living at home with a parent or legal guardian.
Please provide the address: _____

☐ living alone (in an apartment etc.).
Please provide the address: _____

☐ living with a spouse.
Please provide the address: _____

Date Y M D _____

Participant's Signature

PLEASE HAVE THE ATTENDING PHYSICIAN COMPLETE THE STATEMENT ON THE REVERSE

ATTENDING PHYSICIAN STATEMENT

PATIENT IDENTIFICATION:

1- Last Name: _____

First Name: _____ Date of Birth: Y M D

2- Diagnosis(es): _____

3- Initial date of diagnosis: _____

4- Degree of severity: Mild ☐ Moderate ☐ Severe ☐

5- Has the condition: improved? ☐ Effective: Y M D

stabilized? ☐ Effective: Y M D

deteriorated? ☐ Effective: Y M D

6- Medication:

Name of Drug	Dosage	Prescription Date
		Y M D
		Y M D
		Y M D
		Y M D

7- Hospitalization: ☐ No ☐ Yes From Y M D To Y M D

8- Has surgery been performed? ☐ No ☐ Yes Date: Y M D

9- Are you regularly treating this patient? ☐ No ☐ Yes If yes, since when: Y M D

10- Date of the patient's last consultation: Y M D

11- Frequency of follow-ups: _____

12- Has the patient been evaluated by another health care professional? ☐ No ☐ Yes

Specify the specialty: _____ (Attach any available evaluations.)

13- Do you consider the patient totally disabled? ☐ No ☐ Yes Effective: Y M D

14- Is this disability: ☐ temporary ☐ permanent? What is the probable duration of the disability _____

15- In the event of a functional impairment, specify the impairment:

Intellectual	☐	Language – speech	☐
Mental	☐	Hearing	☐ (attach the hearing test)
Organic	☐	Vision	☐ (attach the vision test)
Motor	☐	Multiple	☐ Specify: _____

Is the impairment: ☐ temporary ☐ permanent?

16- Given your patient's medical condition, will a continuation of schooling be possible? ☐ No ☐ Yes

If yes, when will the patient be able to resume studies? Y M D

17- Do you believe the patient will be able to hold any kind of gainful employment in the future? ☐ No ☐ Yes

If yes, when will the patient be able to resume regular activities? Y M D

IDENTIFICATION OF ATTENDING PHYSICIAN

Last Name: _____ First Name: _____

Specialty: _____ Licence No.: _____

Address: _____

Telephone No.: _____ Fax No.: _____

Date: Y M D Signature: _____

Return this form: By fax: 418-651-0894
Toll Free fax: 1-855-453-3942

By mail: Medical Director
SSQ, Life Insurance Company Inc.
Health Insurance Management - Claims
2525 Laurier Boulevard, P.O. Box 10500, Stn Sainte-Foy, Quebec City, QC G1V 4H6