

1- To be completed by the participant				
Name of Participant			Contract No	
Address				
Name of Patient			Age Height (ft, in / m, cm) Weight (lb / kg)	
Relationship to Participant				
If applicable, name, address and telephone number of the estab	lishment w	here care	e was or will be provided:	
N.B. Certain financial assistance programs exist for home assistance s	services. You	may wish 1	ו to contact your local community service centre for more informatio	n.
Are these expenses covered under another insurance contract?	No 🗆	Yes 🗌		
If yes, name of contractholder:			Date of birth:	
Name of other insurer:			Contract No.:	
Coverage status: 🗌 Family 🗌 Single-Parent	🗌 Indiv	dual		
Were these expenses incurred due to an accident in the workplace?	No 🗌	Yes 🗌		
Were these expenses incurred due to an automobile accident?	No 🗌	Yes 🗌		
2- Transportation expenses				
During your convalescence at home, will you have to travel to obtain n	nedical care	or follow-u	-up? No 🗌 Yes 🗌	
Please specify the name(s) of the physician(s) you are required to const	ult:			
PLEASE ATTACH A CERTIFICATE FROM THE PHYSICIAN FOR EACH COL "EXPENSES ARE REIMBURSED ONLY UPON PRESENTATION OF RECEI				

3- Childcare expenses

During your convalescence, will you have to pay for childcare expenses in excess of those usually incurred? No 🗌 Yes 🗌

4- Patient's authorization

I certify that the information provided in this form is true and complete to the best of my knowledge. I hereby authorize the organizations or health professionals involved to communicate to SSQ, Life Insurance Company Inc. any information relating to this benefit claim.

Date

Patient's Signature

N.B.: PLEASE SUBMIT RECEIPTS CLEARLY INDICATING THE NAME, ADDRESS AND TELEPHONE NUMBER OF THE PERSON PROVIDING CHILDCARE OR HOME ASSISTANCE SERVICES.

Please complete both sides of this form.

5- To be completed by the attending physician	
Please answer all questions	
a) Was hospitalization required? No \Box Yes \Box	
If yes, dates of admission and discharge: from	
b) Was day surgery required? No \Box Yes \Box If yes, date of su	rgery:YM
	No \Box Yes \Box If yes, date of emergency consultation: \Box \downarrow \downarrow \downarrow \downarrow \downarrow \downarrow \downarrow
	Number of hours:
d) Please specify the medical reasons that necessitated hospita	alization, day surgery or emergency consultation:
e) Nature of surgery:	
f) Please specify any other health problem(s) your patient suff	ers from:
	Weekly domestic maintenance
Convalescent home Duration: Description of care:	
Functional rehabilitation Duration:	
	rapist 🗌 Others
 i) Is your patient in the terminal phase of an illness (palliative 6- Declaration and identification of attending physician 	care)? No 🗌 Yes 🗌
I hereby certify that the above information is true and complete	e to the best of my knowledge.
Last Name	First Name Licence No.
Date	Physician's Signature - Specialty
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, Station Sainte-Foy Quebec QC G1V 4H6
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