



# HEALTH INSURANCE BENEFIT CLAIM FORM

This form must be used for health claims (drugs, health care professionals, vision care, etc.)

P.O. Box 10500, station Sainte-Foy, Quebec QC G1V 4H6  
P.O. Box #5, Suite 400, 1550-5th Street SW, Calgary (Alberta) T2R 1K3

## SECTION 1 - PARTICIPANT INFORMATION

SSQ Certificate No.			
Last Name		First Name	
Address			
Town/City	Province	Postal Code	Telephone Number

## SECTION 2 - DECLARATION

I declare that all attached expenses have been incurred for :  Myself  My spouse  My dependent children (indicated below)

Is this the first declaration for any of these individuals?  No  Yes, complete section 3

Are these expenses covered under another insurance contract?  No  Yes, complete section 4

Are these expenses the result of an accident?  No  Yes, complete section 5

## SECTION 3 - TO BE COMPLETED IF IT IS THE FIRST CLAIM FOR YOUR SPOUSE OR YOUR DEPENDENT CHILDREN

Last Name	First Name	Date of birth (YYYY-MM-DD)	Gender	Relationship with participant
			<input type="checkbox"/> F <input type="checkbox"/> M	<input type="checkbox"/> Spouse <input type="checkbox"/> Dependent child *
			<input type="checkbox"/> F <input type="checkbox"/> M	<input type="checkbox"/> Spouse <input type="checkbox"/> Dependent child *
			<input type="checkbox"/> F <input type="checkbox"/> M	<input type="checkbox"/> Spouse <input type="checkbox"/> Dependent child *

\* If your child is unmarried, aged between 18 and 26 in accordance to your contract and a full-time student, you must fill out a declaration of school attendance for him or her to remain eligible for insurance benefits as a dependent child. Visit our website at [www.ssq.ca](http://www.ssq.ca) under ACCESS | Plan Member or contact your employer.

## SECTION 4 - TO BE COMPLETED IF YOU HAVE SIMILAR HEALTH INSURANCE COVERAGE WITH ANOTHER INSURER

Name of policyholder	Name of other insurer	Contract Number
Coverage status : Family <input type="checkbox"/> Individual <input type="checkbox"/> Single-Parent <input type="checkbox"/> Couple <input type="checkbox"/>	Benefit type : Drug <input type="checkbox"/> Dental Care <input type="checkbox"/> Visual Care <input type="checkbox"/> Others <input type="checkbox"/>	

## SECTION 5 - TO BE COMPLETED IF THE EXPENSES ARE THE RESULT OF AN ACCIDENT

Name of injured individual : \_\_\_\_\_

Accident date (YYYY-MM-DD) : \_\_\_\_/\_\_\_\_/\_\_\_\_

Accident type:  work  automobile  other \_\_\_\_\_

## SECTION 6 : AUTHORIZATION

I declare the above information to be complete and accurate. I understand that the information I have provided will be used by SSQ, Life Insurance Company Inc. 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.

Participant signature: \_\_\_\_\_ Date : \_\_\_\_/\_\_\_\_/\_\_\_\_

## IMPORTANT

- Send original copies of receipts or invoices and keep copies for your personal records. Originals will not be returned.
- If your claim is for services from a healthcare professional (chiropractor, physiotherapist, etc.), make sure the receipt or invoice clearly states the name of the patient, the date, nature and fees for each treatment and the name of the healthcare professional, the association he or she is a member of and his or her license number.
- Make sure to organize receipts or invoices per patient.