SSQ Financial Group

Notice of Claim
ACCIDENTAL DEATH AND DISMEMBERMENT COVERAGE

SSQ, Insurance Company inc.

110, Sheppard Avenue East, Suite 500
Toronto ON M2N 6Y8
Fax: 416-928-0998

800 - 6th Avenue S.W., Suite 650
Calgary AB T2P 3G3
Fax: 403-261-3101

1225 St-Charles Street West, Suite 200
Longueuil QC J4K 0B9
claims.spgroup@ssq.ca

1. Identification of participant

1.1 Police No.: _____ **1.2 Certificat No.** (if known) : _____ 1.3 Effective Date of Coverage: Y Y Y Y M M D D

1.4 Participant Name: _____ _____ 1.5 Date of Birth: Y Y Y Y M M D D
First Name Last Name

1.6 Home Address: _____ _____ _____ _____
Street City Province Postal Code

1.7 Email: _____

1.8 Occupation: _____ 1.9 Class/Division: _____

1.10 Amount of Principal Sum: **Basic:** _____ **Optional:** _____ **1.11 Optional Policy No.** (if different): _____

1.12 Beneficiary(ies)*: _____ * Please attached a copy of the beneficiary designation form.

2. Identification of insured deceased / injured

☐ Participant (go to question 2.4) ☐ Spouse ☐ Dependent Child

2.1 Insured Name: _____ _____ 2.2 Date of Birth: Y Y Y Y M M D D
First Name Last Name

2.3 Address (if different than participant): _____ _____ _____ _____
Street City Province Postal Code

2.4 Date of Accident: Y Y Y Y M M D D 2.5 Place of Accident: _____

2.6 Date of loss/death: Y Y Y Y M M D D

2.7 Nature of Loss (Life, Paralysis, Loss of Use of One Arm, etc.): _____

2.8 Circumstances of Accident: _____

2.9 In the event of death of the participant, please advise if he/she left: Spouse: ☐ Yes ☐ No ☐ Unknown / Dependent Child(ren): ☐ Yes ☐ No ☐ Unknown

Name of Spouse: _____ Date of Birth: Y Y Y Y M M D D

Name of Child(ren): _____ Date of Birth: Y Y Y Y M M D D

3. Identification of employer / Policyholder

3.1 Employer / Policyholder: _____

3.2 Representative Name: _____ 3.3 Telephone No.: _____

3.4 Email: _____

4. Identification of the person reporting the loss

4.1 First Name and Last Name: _____

4.2 Relationship to participant: ☐ Employer/Policyholder ☐ Broker ☐ Participant ☐ Beneficiary ☐ Other

4.3 Email: _____ 4.4 Telephone No.: _____

4.5 Send claim forms to the attention of: _____

4.6 Address: _____

_____ Y Y Y Y M M D D
Signature of the person reporting the loss Date