SSQ Financial Group

Values in the right place

ACCIDENTAL FRACTURE OR SEVERING

CLAIMANT'S STATEMENT

SSQ Insurance Company Inc., 1225 Saint-Charles Street West, Suite 200, Longueuil, Quebec J4K 0B9

INSTRUCTIONS

1. Fill out the claimant's statement and sign and date.
2. Have the back filled out by the attending physician.
3. All costs incurred are at the claimant's expense.

POLICY NO.

Claimant's Identification

Surname and First Name

Address

Province

Postal Code

Sex: ☐ F ☐ M

Y Y Y Y M M D D
Date of birth

Home Phone

Work Phone

Claimant's Statement

Circumstances of the accident

Y Y Y Y M M D D
Date of the accident

Place of the accident

Y Y Y Y M M D D
Date of the first medical consultation for this accident

Y Y Y Y M M D D
Date on which you ceased your work or your daily activities because of this accident

Name of the physician consulted following this accident

Physician's Address

Name and address of one witness to the accident

1.

Address

Telephone

2.

Address

Telephone

I STATE THAT THE ANSWERS ABOVE ARE COMPLETE AND TRUTHFUL.
ALL COSTS INCURRED IN FILLING OUT THE FORM ARE AT THE CLAIMANT'S EXPENSE.

X

Claimant's Signature

Y Y Y Y M M D D
Date

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BENEFIT IN CASE OF ACCIDENTAL FRACTURE OR SEVERING ACCIDENT

STATEMENT OF THE ATTENDING PHYSICIAN

SSQ Insurance Company Inc., 1225 Saint-Charles Street West, Suite 200, Longueuil, Quebec J4K 0B9

INSTRUCTIONS

1. Fill out the attending physician's statement and return it to the patient.
2. All costs incurred are at the patient's expense.

PATIENT'S SURNAME AND FIRST NAME

Attending Physician's Statement

Y Y Y Y M M D D
Date of the accident

Y Y Y Y M M D D
Date of the first treatment for this fracture or severing

MAIN DIAGNOSIS

IS THE PATIENT'S STATE:
due to an accident? ☐ No ☐ Yes

Yes If yes, is it a: ☐ work accident ☐ motor vehicle accident ☐ other
Specify:

TYPE OF FRACTURE SUFFERED FOLLOWING ACCIDENT? *ATTACH THE RADIOLOGIST'S REPORT*

☐ Skull ☐ Larynx ☐ Ulna ☐ Femur
☐ Vertebral column ☐ Trachea ☐ Patella ☐ Radius
☐ Pelvis (hip bone) ☐ Scapula ☐ Tibia ☐ Fibula
☐ Sternum ☐ Humerus ☐ Other, specify:

WAS THE FRACTURE OR SEvERING DUE SOLELY TO THE ACCIDENT IN QUESTION?
☐ No ☐ Yes

IF NOT, COULD A PREVIOUS ILLNESS OR CONDITION HAVE CAUSED THE FRACTURE OR SEVERING INDIRECTLY? ☐ No ☐ Yes
If yes, specify:

TYPE OF TREATMENT (SURGERY, PHYSIOTHERAPY, PRESCRIBED MEDICATION, ETC.)

WAS THE PATIENT HOSPITALIZED?
☐ No ☐ Yes

IF YES, NAME OF THE INSTITUTION

COMMENTS AND PERTINENT INFORMATION

Doctor's Identification

Nom, prénom du médecin traitant (BLOCK LETTERS)

Licence No.

Telephone

☐ General practitioner ☐ Specialist, specify:

Fax

X
Attending Physician's Signature

Y Y Y Y M M D D
Date