

<b>Patient</b> Last Name: _____ First Name: _____ Address: _____ Apt.: _____ Town/City: _____ Province: _____ Postal Code: _____ Telephone: _____	<b>Dentist</b> Name: _____ Address: _____ Town/City: _____ Province: _____ Postal Code: _____ Telephone: _____ Unique No.: _____
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DATE OF SERVICE			INT'L TOOTH CODE	PROCEDURE CODE	TOOTH SURFACES	LABORATORY CHARGE	DENTIST'S FEE	TOTAL FEES CLAIMED	FOR SSQ USE ONLY	
Y	M	D								
THIS IS AN ACCURATE DESCRIPTION OF THE TREATMENT PROVIDED AT THE DATE OF SERVICE INDICATED (OR TO BE PROVIDED IN THE CASE OF A TREATMENT PLAN) AND OF THE CORRESPONDING FEES CHARGED AND PAID.							TOTAL FEES CHARGED: ▶			
							TOTAL FEES PAID BY THE PATIENT: ▶			
DENTIST'S SIGNATURE _____							DATE			
FOR DENTIST'S USE ONLY TO INCLUDE ADDITIONAL INFORMATION (USE BACK OF FORM IF NECESSARY).										
							COMPLETED BY: _____		DATE: _____	

**A) TO BE COMPLETED BY THE PARTICIPANT**

1. a) PATIENT'S RELATIONSHIP TO PARTICIPANT: \_\_\_\_\_

PATIENT'S DATE OF BIRTH

Y    M    D

|\_|\_|    |\_|\_|    |\_|\_|

b) FOR AN OVERAGE DEPENDENT, INDICATE IF UNMARRIED AND A FULL-TIME STUDENT:     NO     YES

c) NAME OF SCHOOL: \_\_\_\_\_

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2. a) IS THIS TREATMENT COVERED UNDER ANY OTHER INSURANCE PLAN?     NO     YES

b) IF «YES», NAME OF THE COMPANY AND POLICY NUMBER: \_\_\_\_\_

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3. IS THIS TREATMENT REQUIRED DUE TO AN ACCIDENT?     NO     YES

IF «YES», COMPLETE BACK OF FORM

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4. IF CLAIM IS FOR DENTURES, CROWN OR BRIDGE, IS THIS AN INITIAL PLACEMENT?     NO     YES

IF «NO», GIVE DATE OF PRIOR PLACEMENT AND REASON FOR REPLACEMENT:

Y    M    D

|\_|\_|    |\_|\_|    |\_|\_|

CONTRACT NO. \_\_\_\_\_    CERTIFICATE NO. \_\_\_\_\_

PARTICIPANT'S LAST NAME \_\_\_\_\_

PARTICIPANT'S FIRST NAME(S) \_\_\_\_\_

ADDRESS \_\_\_\_\_

POSTAL CODE \_\_\_\_\_

I UNDERSTAND THAT THE FEES INDICATED IN THIS CLAIM MAY NOT BE COVERED BY, OR MAY EXCEED, MY PLAN BENEFITS. I ACKNOWLEDGE THAT THE TOTAL FEES AND THE DATES OF SERVICE INDICATED IN THIS FORM ARE ACCURATE AND THAT I WAS CHARGED FOR AND HAVE PAID THE TOTAL FEES SPECIFIED. I AUTHORIZE RELEASE OF THE INFORMATION CONTAINED IN THIS CLAIM FORM TO MY INSURER, SSQ, LIFE INSURANCE COMPANY INC., AND ITS AGENTS. I ALSO AUTHORIZE MY INSURER, SSQ LIFE INSURANCE COMPANY INC., AND ITS AGENTS, TO DISCLOSE ANY INFORMATION CONTAINED IN THIS FORM AS REQUIRED FOR THE EXAMINATION AND ADMINISTRATION OF THIS CLAIM.

Y    M    D

|\_|\_|    |\_|\_|    |\_|\_|

SIGNATURE OF PATIENT (OR PARENT/LEGAL GUARDIAN) \_\_\_\_\_    DATE \_\_\_\_\_

I CERTIFY THAT THIS INFORMATION IS TRUE, ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

Y    M    D

|\_|\_|    |\_|\_|    |\_|\_|

PARTICIPANT'S SIGNATURE \_\_\_\_\_    DATE \_\_\_\_\_

