SSQ Financial Group

HEALTH INSURANCE BENEFIT CLAIM

P.O. Box 10500, Station Sainte-Foy, Quebec QC G1V 4H6

SECTION 1

CONTRACT NO. ___ – ___ – ___ **GENDER** M ☐ F ☐ **SOCIAL INSURANCE NUMBER** ___ – ___ – ___

NAME OF PARTICIPANT:

ADDRESS:

POSTAL CODE:

TOWN/CITY: **PROVINCE:**

COVERAGE STATUS: FAMILY ☐ INDIVIDUAL ☐ SINGLE-PARENT ☐ COUPLE ☐

IMPORTANT

Complete this coupon and attach your receipts.
Please send only original copies of receipts or paid invoices.
Please keep a copy of all documents sent as receipts will not be returned.
Official prescription receipts should be grouped in order by date of purchase.
You are invited to file your claims at regular 3-month intervals.

I DECLARE THAT ALL ATTACHED EXPENSES HAVE BEEN INCURRED FOR:

MYSELF ☐ **MY SPOUSE** ☐ **MY DEPENDENT CHILDREN (INDICATED BELOW)** ☐

If your child is studying full time, complete Section 3 below.

FIRST NAME	DATE OF BIRTH Y	M	D

ARE THESE EXPENSES COVERED UNDER **ANOTHER INSURANCE CONTRACT**? NO ☐ YES ☐ **IF YES, COMPLETE SECTION 2 BELOW.**
ARE THESE EXPENSES THE RESULT OF A **WORK ACCIDENT**? NO ☐ YES ☐
ARE THESE EXPENSES THE RESULT OF AN **AUTOMOBILE ACCIDENT**? NO ☐ YES ☐

I authorize the organizations or health professionals involved to provide SSQ, Life Insurance Company Inc., with information regarding this claim.

___ TEL.: ___
DATE SIGNATURE

SECTION 2

TO BE COMPLETED IF YOU HAVE SIMILAR HEALTH INSURANCE COVERAGE WITH ANOTHER INSURER

NAME OF POLICYHOLDER

DATE OF BIRTH Y M D

NAME OF OTHER INSURER

CONTRACT NO.

COVERAGE STATUS

FAMILY ☐
INDIVIDUAL ☐
SINGLE-PARENT ☐
COUPLE ☐

SECTION 3

TO BE COMPLETED FOR AN OVERAGE DEPENDENT IF UNMARRIED AND STUDYING FULL TIME

I DECLARE THAT MY CHILD _____ **, BORN ON** ___ ___ ___ **,**
NAME OF CHILD Y M D

IS UNMARRIED AND IS ENROLLED AT THE HIGH SCHOOL, COLLEGE OR UNIVERSITY _____
NAME OF SCHOOL, COLLEGE OR UNIVERSITY

AS A FULL-TIME STUDENT FOR THE 20 _____ **- 20** _____ **ACADEMIC YEAR , AND IS FOLLOWING A COURSE OF STUDY IN** _____

DATE

SIGNATURE OF PARTICIPANT