

HEALTH CLAIM FORM

SSQ, Insurance Company Inc. 1225 St-Charles Street West, Suite 200 • Longueuil (QC) • J4K 0B9 Fax : 1-855-690-9895

Email: claims.spgroup@beneva.ca

1. Statement of the Participant

1.1. Policy No.:	1.2. Certificate No.: (if kno	wn)				
1.3. Participant Name			1.4. Date of Birth	D	М	Υ
First Name	Last Name					
1.5. Dependent's Full Name (if applicable)		Relationsh	ip to Participant	Date of	·	
				D	M	Y
				D	М	Y
				D	М	Y
				D	М	Υ
(if space is insufficient, please use a separate shee 1.6. Name and address of post-secondary Please include Proof of Registration/E	school he/she is currently at	ttending if de	pendent child is age 21 c	r older.		
1.7. Complete Address in Canada Stree	ot .	City	Province	Pos	tal Code	
400		•				
1.9. Email Address						
1.10. If Expatriate – indicate date of depa	rture from place of posting	D	M Y			
expected date o	of return to place of posting	D	M Y			
1.11. Are you eligible for benefits under a	Provincial Health Plan?	☐ Yes ☐	No			
Are your dependents eligible for ber	nefits under a Provincial Hea	ılth Plan?	☐ Yes ☐ No			
Do you have any other medical plan			please complete the follo	owing :		
Name of eligible family member :				•		
Name of Insurance Company admir			•			
Policy Number	Type of insurance					
2. Direct deposit						
Please provide the following information	if you would like your claim p	payment dep	osited to a Canadian bar	nk accour	nt:	
Bank # Transit #	Account #	‡ <u></u>	Please attach a "\	/oid" che	eque	
For a direct deposit in a foreign currency	, please complete the Autho	rization Dired	ct Deposit/ Bank Transfer	form.		
3. Remit Payment to Provider	(To be completed by the employ	ee if cheque is t	o be made payable to the Provic	ler)		
I hereby assign to benefits payable to me, but not to exceed the charge for the services described on this claim form. I understand that I am financially responsible for charges not covered by this assignment. I certify to the best of my knowledge that the statements made are true, correct and complete.						
	D M	Υ	()		
Signature of Participant	Date		Tele	phone N	umber	

4. Health Claim Section

(to be completed by the Claimant)

Policy No.:	
-------------	--

Important - Send original copy of receipts or invoice (Keep copies for personal records. Originals will not be returned.)

Final P		Claimed services : Drug name and strength of each prescription (if not for	Date of	0-1				
First Name of Claimant	Nature of Illness/Injury	drugs, state the nature of the expense)	Receipt (D-M-Y)	Cost of each item	Country and Currency			
5. Attendi	ng Physician's Inforr	mation			,			
5.1. Physician	's Name		5.2.	Speciality				
5.3. Address	Street							
					Destal Code			
F 4 Tolophon	City	Province / C	ountry		Postal Code			
5.4. Telephone	e <u>(</u>)	5.5. Fax (
6. Authoriz	zation							
I declare the above information to be complete and accurate. I understand that the information I have provided will be used by SSQ, Insurance Compagny 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.								
		DM	Υ		()			
Signature of F	Participant	Date			Telephone Number			