HEALTH CLAIM FORM

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

1. Statement of the Participant

1.1. Policy No.: ..... **1.2. Certificate No.:** (if known) .....

1.3. Participant Name .... 1.4. Date of Birth D M Y
First Name Last Name

1.5. Dependent's Full Name (if applicable)	Relationship to Participant	Date of Birth
		D M Y
		D M Y
		D M Y
		D M Y

(if space is insufficient, please use a separate sheet of paper)

1.6. Name and address of post-secondary school he/she is currently attending if dependent child is age 21 or older.
Please include Proof of Registration/Enrollment

.....

1.7. Complete Address in Canada .....
Street City Province Postal Code

1.8. Complete Address outside Canada .....

1.9. Email Address .....

1.10. If Expatriate – indicate date of departure from place of posting D M Y

expected date 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 benefits under a Provincial Health Plan? ☐ Yes ☐ No

Do you have any other medical plan? ☐ Yes ☐ No If "Yes", please complete the following :

Name of eligible family member : ..... Relationship : .....

Name of Insurance Company administering the Plan .....

Policy Number ..... Type of insurance .....

2. Direct deposit

Please provide the following information if you would like your claim payment deposited to a **Canadian** bank account:

Bank # ..... Transit # ..... Account # ..... **Please attach a "Void" cheque**

For a direct deposit in a foreign currency, please complete the *Authorization Direct Deposit/ Bank Transfer* form.

3. Remit Payment to Provider

(To be completed by the employee if cheque is to be made payable to the Provider)

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 Y ( )
Signature of Participant Date Telephone Number

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.)

First Name of Claimant	Nature of Illness/Injury	Claimed services : Drug name and strength of each prescription (if not for drugs, state the nature of the expense)	Date of Receipt (D-M-Y)	Cost of each item	Country and Currency

5. Attending Physician's Information

5.1. Physician's Name ..... 5.2. Speciality .....

5.3. Address .....
Street

....
City Province / Country Postal Code

5.4. Telephone ( ) ..... 5.5. Fax ( ) .....

6. Authorization

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.

..... D M Y ..... ( ) .....
Signature of Participant Date Telephone Number