INPATRIATE/EXPATRIATE MEDICAL & EXTENDED HEALTH CLAIM FORM

SSQ Insurance Company Inc.

Please answer all questions fully – it helps us to provide better service.

All questions can be completed in ink (please print), however, the form must be signed and dated by ALL parties.
Emailed, faxed or photocopied forms (once completed) are unacceptable for claims purposes.

Instructions to Insured:

1. Complete the Insured's Statement Section and the Extended Health Claim Section on Page 2.
2. Have your Physician complete the Attending Physician's Section if the claim is over $500.00.
3. Return the completed form to your Employer.
4. Please retain copies of receipts for your files, as originals will not be returned.

Instructions to Employer:

Complete the Employer Section and return the ORIGINAL signed form in its entirety along with ORIGINAL medical receipts to **SSQ Insurance Company Inc.** at any of the following addresses:

SSQ Place, 110 Sheppard Avenue East, Suite 500, Toronto, Ontario M2N 6Y8
2020 University Street, Suite 700, Montreal, Quebec H3A 2A5
800 - 6th Avenue S.W., Suite 650, Calgary, Alberta T2P 3G3

Insured's Statement Section

(to be completed in full by the Insured)

Policy Number: _____

1. Insured's Full Name _____ Date of Birth D M Y
2. Dependent's Full Name (if applicable) | Relationship to Employee | Date of Birth D M Y

_____ | _____ | D M Y

_____ | _____ | D M Y

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

3. Is the claim for a dependent child, age 21 or older? ☐ Yes ☐ No
4. Name and address of post-secondary school he/she is currently attending :

_____

5. Complete Address in Canada _____
   Number & Street City Province Postal code
6. Complete Address outside Canada _____
7. Are you or your dependents eligible for benefits under a Provincial Health Plan? ☐ Yes ☐ No

   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 _____

Assignment

(To be completed by the employee if cheque is to be made payable to the Provider.) This assignment is limited to physicians and hospitals for payment over $500.00.
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 Insured Employee Date Telephone Number

Please return completed claim form with the "Consent to collect, use and disclose personal information" form.

Policy Holder's Statement Section

(to be completed by the Policy Holder)

1. Name of Employee _____ Division/Class (if applicable) _____
2. Effective Date of Employee's Coverage D M Y
3. Effective Date of Dependent's Coverage D M Y
4. Termination Date of Coverage D M Y
5. Is claim being filed for Worker's Compensation Benefits/WSIB? ☐ Yes ☐ No If "Yes", claim number _____
6. Employer's Name _____ Telephone No. ( )
7. Address _____
   Number & Street City Province Postal code

_____ _____ _____

Authorized Signature Print Name Official Position/Title

Attending Physician's Section

(to be completed by the Attending Physician) **Policy Number:** _____

1. Diagnosis (describe complications, if any) and Procedures

2. When did the patient first consult you for this condition? D M Y

3. To the best of your knowledge, when did the symptoms first appear or accident happen? D M Y

4. Has the patient ever had same or similar condition? ☐ Yes ☐ No

   If "Yes", state particulars

5. Describe any other disease or infirmity affecting the patient's present condition :

6. Is the condition due to pregnancy? ☐ Yes ☐ No

7. If "Yes", what was the approximate date of commencement of pregnancy? D M Y

8. Was the patient hospitalized? ☐ Yes ☐ No If "Yes", From D M Y To D M Y

9. Name and address of hospital

10. If an operation was performed, state the nature of the operation

11. Date Performed D M Y 12. By Doctor

13. Physician's Name (please print) Telephone No. ( )

    Address
    Number & Street City Province Postal Code

    Date D M Y Physician's Signature _____

The patient is responsible for securing the Attending Physician's Statement and for any charges made for its completion.

Extended Health Claim Section

(to be completed by the Employee)

Instructions: All claims must be accompanied by the original receipts, itemized statements or invoices; treatment and diagnosis must be included. Photocopies will not be accepted. If space is insufficient, please use a separate sheet of paper.

Important: Please complete the form in full to avoid delay in processing your claim.

First Name of Claimant	Nature of Illness/Injury	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	**For Office Use Only** Currency Rate	Canadian Funds