# PROOF OF LOSS
## STUDENT ACCIDENT INSURANCE

**SSQ Insurance Company Inc.**

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

**Instructions:** Insured Student complete Claimant Statement Section; School Administrator complete School Declaration at bottom of page 1. Attending Physician complete Physician Statement Section on page 2.

**Important:** If Injury involves teeth, please complete Accidental Dental Claim Form. If the Member is covered under any other Medical insurance plan, the expenses must be submitted to that plan. If there is any unpaid balance, please attach their Payment Statement. Please retain copies of receipts for your files, as originals will not be returned.

**Note:** This form can be completed in ink (please print), however, the form must be signed and dated by ALL parties and then the ORIGINAL, signed form in its entirety must be returned 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 1800, Montreal, Quebec H3A 2A5**

**800 - 6th Avenue S.W., Suite 650, Calgary, Alberta T2P 3G3**

Emailed, faxed or photocopied forms (once completed) are unacceptable for claims purposes.

## Claimant's Statement

**Policy Number:** **SSQ 1GX80**

1. Insured Person's Full Name _____ 2. Date of Birth D M Y
3. If Injured Person is a minor, give Full Name of Parent or Guardian _____

Address _____
Street City Province Postal Code

4. Is the Injured Person a Canadian resident? ☐ Yes ☐ No
5. What is the name of the school board and district _____
6. What was the date of the accident D M Y
7. Where did accident occur? _____
8. Describe injury _____
9. Describe fully how accident occurred _____
10. What was the date of first treatment by doctor D M Y
11. Full Name of Physician _____ Telephone No. ( )

Address _____
Street City Province Postal Code

12. Give dates of treatment

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| At Home | D M Y | | Office | D M Y | | Hospital | D M Y | |
| At Home | D M Y | | Office | D M Y | | Hospital | D M Y | |
| At Home | D M Y | | Office | D M Y | | Hospital | D M Y | |

13. Name of hospital if treated in hospital _____
14. Date treated in hospital D M Y
15. Do you have any other Hospital or Medical Insurance? ☐ Yes ☐ No

Plan Name/Policy Number _____

**I certify to the best of my knowledge that the statements made above are true, correct and complete.**

_____ ( ) D M Y
Insured Person's Signature (or Signature of Parent or Guardian if injured member is a minor) Telephone Date

Complete Address _____
Street City Province Postal Code

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

## School Declaration

1. Name of School _____
2. Complete Address _____
Street City Province Postal Code
3. Effective date of Student's coverage D M Y
4. Was the student injured during an approved activity? ☐ Yes ☐ No

_____ _____ _____
School Official Signature Print Name Official Position/Title

Policy Number _____ Telephone ( ) Date D M Y

## Attending Physician Statement Section

**Policy Number** 1GX80

1. Patient's Name _____ 2. Patient's Date of Birth D M Y

3. Diagnosis of present condition _____

   (a) Primary _____

   (b) Secondary (if applicable) _____

4. On what dates did you examine the patient? D M Y | D M Y | D M Y

5. To the best of my knowledge

   (a) Symptoms first appeared or accident happened D M Y

   (b) Patient has had same or similar condition? ☐ Yes ☐ No

   If "Yes", state particulars _____

6. If attended at hospital, name of hospital _____

   Admitted D M Y Time _____ AM/PM

   Discharged D M Y Time _____ AM/PM

7. If surgery performed, describe _____

8. If patient referred to you, give name of referring physician _____

9. Have you referred the patient to a specialist for additional treatments? ☐ Yes ☐ No

   If "Yes", please explain _____

10. Have you referred the patient for physiotherapy treatments? ☐ Yes ☐ No If yes, date such referral was made: D M Y

    Frequency and duration of physiotherapy treatments? _____

11. To the best of my knowledge, the patient has been totally disabled (unabled to attend school)

    From D M Y to D M Y inclusive

12. If still disabled, what date should the patient be able to return to school? D M Y

    Or, if indefinite, what is the estimated number of weeks before such return _____ additional weeks.

    How long was or will the patient be partially disabled (able to attend part-time school)?

    From D M Y to D M Y inclusive

Physician's Name (Print) _____ Physician's Signature _____

Address _____
Street City Province Postal Code

Telephone ( ) Date D M Y

*The patient is responsible for securing this form and for any charges made for its completion.*