

PROOF OF LOSS ACCIDENTAL MEDICAL (SPORTS INSURANCE)

SSQ Insurance Company Inc. 2020 University Street, Suite 1800, Montreal, Quebec H3A 2A5

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

Instructions: Injured Member complete Insured Statement Section; Team Manager or Administrator complete Club Section 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:

Exchange Tower 130 King Street West 23rd floor, Suite 2350, PO BOX 160, Toronto Ontario, M5X 1C7 2020 University Street, Suite 1800, Montreal, Quebec H3A 2A5 220 - 12th Avenue S.W., suite 600, Calgary (Alberta) T2R 0E9

Emailed, faxed or photocopied forms (once completed) are unacceptable for daims

1. Insured Member's Full Name 2. Date of Birth	Insured Statement Section	Policy Num	ber:
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The patient is responsible for securing this form and for any charges made for its completion.