NSCC Student Accident Insurance: Non-Dental

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

Instructions: Insured Student, parent or guardian to complete Claimant Statement Section; School Administrator to complete School Declaration; Attending Physician to complete Attending Physician Section. (**Attending Physician Statement does not have to be completed if claim is for ambulance bill only or for claims of $100.00 or less**)

Important: If injury involves teeth, please complete Student Accident Insurance: Dental 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 must be completed in ink (please print), then signed and dated by ALL parties. The *original, signed form in its entirety must be returned along with original medical receipts to:

SSQ Insurance Company Inc.
1225 St-Charles Street West, Suite 200
Longueuil QC J4K 0B9
1-855-395-2520

* Receipts and claim forms can be sent via e-mail to **claims.spgroup@ssq.ca**; however, the claimants must keep the original forms should SSQ require them for audit purposes. Faxed copies are not acceptable.

Claimant's Statement

Policy Number: 1JM65

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 ☐ Handicapped 5. Telephone No. ( )

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 physician? 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 _____

College Declaration (to be completed by the College Administrator)

1. Name of Institution _____
2. Complete Address _____
Street City Province Postal Code

3. Is the student a:
☐ Daycare Attendee
☐ Resident Student enrolled in an NSCC training program (A resident student is a student of the Institution who resides in a dwelling situated on the premises of the Institution
☐ Non-Resident Student enrolled in an NSCC training program

College Official's Signature | Print Name | Official's Position/Title

( ) Telephone | D M Y Date

I authorize SSQ Insurance Company Inc. and its authorized representatives to collect, use, and disclose personal information about me and, where applicable, my dependent children as permitted by law from and to the following persons and organizations:

- any licensed medical practitioner or licensed health professional, hospital, clinic or medically related facility;
- any other insurance company or financial institution, including any reinsurance company;
- any other person or organization with information relevant to my claim; and
- any person or organization that provides information services or insurance services to, or that acts as insurance intermediary for SSQ Insurance Company Inc.

For the following purposes:

- establishing and maintaining communications with me;
- underwriting group risks on a prudent basis;
- investigating and settling claims;
- detecting and preventing fraud;
- offering and providing products and services to meet my needs;
- compiling insurance statistics; and
- complying with the law.

The personal information collected by SSQ Insurance Company Inc. will be entered into a file whose subject is accident and sickness insurance. The file will be kept at SSQ Insurance Company Inc. offices. Within SSQ Insurance Company Inc., this file will only be accessed by those employees who require access in order to fulfill the purposes listed above. I understand that I may access my personal information contained in this file and correct such information if necessary by directing a written request to:

Privacy Officer
SSQ Insurance Company Inc
1200 Papineau Avenue, Suite 460
Montreal, Quebec H2K 4R5

This consent shall be valid for the length of time necessary for SSQ Insurance Company Inc. to achieve the purposes listed above. I may withdraw this consent at any time by giving SSQ Insurance Company Inc. written notice of withdrawal. I understand that withdrawal of my consent might result in SSQ Insurance Company Inc. being unable to provide me with a product or service. A copy of this consent shall be considered as effective and valid as the original.

	( )	D M Y
Insured person's signature (or signature of parent or guardian if injured person is a minor)	**Telephone**	**Date**

Attending Physician Statement (Not to be completed if claim is for an ambulance bill only or for claims of $100.00 or less)

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 (unable 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

( ) _____ D M Y
Telephone Date

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