Student Accident Insurance: Dental Claim Form

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

Important: If injury involves teeth, please complete this Student Accident Insurance: Dental form. If the Member is covered under any other Extended Health or Dental insurance plan, the expenses must be submitted to the Extended Health plan (Accidental Dental Benefit) and then to this Dental plan. If there is any unpaid balance, please attach their Payment Statement(s). 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.

Patient Information

Policy Number: 1JN25

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. Nova Scotia International Student Program? ☐

7. What was the date of the accident? D M Y

8. Where did accident occur? _____

9. Nature of injury _____

10. Describe fully how accident occurred _____

11. Full name of Dentist _____ Date of first treatment D M Y

12. Name of hospital if treated in hospital _____

Date admitted D M Y Time _____ ☐ am ☐ pm

Date discharged D M Y Time _____ ☐ am ☐ pm

School Declaration (to be completed by the School Administrator)

☐ **Gold Plan**

1. Name of School Board _____

2. Name of School _____

3. Complete Address _____
Street City Province Postal Code

4. Effective date of student's coverage D M Y (1st day of current school year)

5. School approved activity? ☐ Yes ☐ No

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

( ) Telephone

D M Y Date

Employee / Plan Member / Subscriber (to be completed if there is coverage under another plan)

Member's Name _____ Date of Birth D M Y

Group Policy / Plan Number _____ Division Section Number _____

Employer _____

Name of insuring agency or plan _____

Patient Name _____ Relationship to Employee / Plan Member / Subscriber _____

Do you have coverage for dental expenses under any of the following:

Group Health Plan? ☐ Yes ☐ No Plan Name / Policy No. _____

Group Dental Plan? ☐ Yes ☐ No Plan Name / Policy No. _____

W.C.B. Plan? ☐ Yes ☐ No Plan Name / Policy No. _____

Government Plan? ☐ Yes ☐ No Plan Name / Policy No. _____

*** Nova Scotia International Student Program:** Students must have attached a notarized custodian agreement for the claim to be processed.

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 Dentist Statement

Unique No. _____ Spec. _____ Patient's Office Account No. _____

Dentist's Name: Address: Phone No. ( )	I hereby assign any benefits payable from this claim to the named dentist and authorize payment directly to him/her. _____ Signature of patient (parent / guardian)	**For Dentist use only** ☐ **Duplicate form** (for additional information, diagnosis, procedures or special consideration)

I understand that the fees listed in this claim may not be covered by or may exceed my plan benefits. I understand that I am financially responsible to my dentist for the entire treatment. I acknowledge that the total fee of $_____is accurate and has been charged to me for services rendered. I authorize release of the information contained in this claim form to my insuring company / plan administrator.

_____ _____

Signature of patient (parent / guardian) ☐ Office Verification

Date of Service (D/M/Y)	Procedure Code	Intl. Tooth Code	Tooth Surfaces	Dentist's Fees	Laboratory Charges	**Total Charges**

For Carrier Use:

Allowed Amt.	Inc.	%	Patient's Share

Cheque No.	Date (D/M/Y)

Deductible	Patient Pays	Plan Pays

This is an accurate statement of services performed and the total fee due and payable, E & OE.

Total Fee Submitted:
$_____

Claim Number _____

Dentist's Supplementary Report

1. Description of damage _____

2. Is further treatment indicated? ☐ Yes ☐ No If "Yes", please indicate:

Int. Tooth Code	Treatment Indicated – use procedure code if possible	Estimated Date – Treatment (D/M/Y)

3. Describe further potential problems and indicate time frame _____

4. A) How many teeth were injured? _____ B) Were these whole or sound teeth? ☐ Yes ☐ No C) How many of these teeth had fillings? _____

   D) How many of these injured teeth had crowns? _____ E) How many of these injured teeth had root canal treatment? _____

   F) If not whole or sound teeth, explain reason why _____

Dentist's Signature _____ **Date** **D** **M** **Y**