

# 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](mailto: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: **1JN25**

- Insured person's full name \_\_\_\_\_ 2. Date of Birth    D    M    Y \_\_\_\_\_
- If injured person is a minor, give full name of parent or guardian \_\_\_\_\_  
Address \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ Province \_\_\_\_\_ Postal Code \_\_\_\_\_
- Is the injured person a Canadian Resident?  Yes  No Handicapped \_\_\_\_\_ 5. Telephone No.    (    ) \_\_\_\_\_
- Nova Scotia International Student Program
- What was the date of the accident?    D    M    Y \_\_\_\_\_
- Where did accident occur? \_\_\_\_\_
- Describe injury \_\_\_\_\_
- Describe fully how accident occurred \_\_\_\_\_  
\_\_\_\_\_
- What was the date of first treatment by physician?    D    M    Y \_\_\_\_\_
- Full name of physician \_\_\_\_\_ Telephone No.    (    ) \_\_\_\_\_  
Address \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ Province \_\_\_\_\_ Postal Code \_\_\_\_\_
- 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 \_\_\_\_\_
- Name of hospital if treated in hospital \_\_\_\_\_
- Date treated in hospital    D    M    Y \_\_\_\_\_
- Do you have any other Hospital or Medical Insurance?  Yes  No Plan Name/Policy Number \_\_\_\_\_

## School Declaration (to be completed by the School Administrator)

Gold Plan

- Name of School Board \_\_\_\_\_
- Name of School \_\_\_\_\_
- Complete Address \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ Province \_\_\_\_\_ Postal Code \_\_\_\_\_
- Effective date of student's coverage    D    M    Y \_\_\_\_\_ (1<sup>st</sup> day of current school year)
- School Approved Activity?  Yes  No

\_\_\_\_\_  
School Official Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Official's Position/Title

(    ) \_\_\_\_\_  
Telephone

   D    M    Y \_\_\_\_\_  
Date

**\*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.

\_\_\_\_\_  
**Insured person's signature**  
(or signature of parent or guardian if injured person is a minor)

( ) \_\_\_\_\_  
**Telephone**

D     M     Y  
\_\_\_\_\_  
**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

( ) \_\_\_\_\_

Telephone

         D M Y

Date

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