

PROOF OF LOSS FOR ACCIDENT

STUDENT INSURANCE – DENTAL CLAIM

SSQ, Insurance Company Inc, 1225 St-Charles Street West, Suite 200 • Longueuil (QC) • J4K 0B9 Fax: 1-855-690-9895 • Email: claims.spgroup@ssq.ca

1. CLAIMANT'S STATE	MENT						
4.1. Policy No. 1J	IN25	4.2. Certificate N	NO. (if known)				
 4.3. Insured Name Given N 4.5. Is the Injured Person a C 4.6. If Injured Person is a minor 	anadian resident?	Family Name	4.5B. Is the Injur		l Plan member?		nt (NSISP)?
4.7. Address					Province		Postal Code
4.9. Name of the School Board		4.44					
			lace of accident				
4.12. Describe injury 4.13. Describe fully how accide							
4.14. Date of first treatment	D M Y		Date treated in hos		Y (
4.16. Full Name of Physician				•	ohone No. ()	
4.17. Name of Hospital if applie4.18. Do you have any other H							
Plan Name/Policy Number							
I certify to the best of my k provided will be used by SSQ, them to process this claim.	nowledge that the s	statements made a	bove are true, c	prrect and comp nay be shared wi	blete. I understant th third parties of		
Insured Person's Signature (Par	rent or Guardian if injurec	I member is a minor)		D M Date	Y (Tele) ephone	
2. DIRECT DEPOSIT							
Please provide the following Bank #	information if you wo Transit #		ayment deposited		ank account: attach a "Void"	cheque	
3. SCHOOL DECLARAT	ΓΙΟΝ						
3.1. Name of School							
3.2. Complete Address	eet		City		Province		Postal Code
3.3. Name of Administrator				3.4. Official Pos			
3.5. Effective date of Student's	s coverage D	M Y		3.6. Policy No.	1JN25		
3.7. Was the student injured d	uring an approved ac	tivity? 🗌 Yes 🗌] No	_			
School Official Signatu	re			D M Date	Y (Tele) ephone	

4. DENTIST					Policy No.: 1JN25					
Unique No.		s	pec.				Patient's Of	fice Account Number		
Patient's Nan	Patient's Name		Dentist	Dentist's Name			For Dentist use only Duplicate form (for additional information, diagnosis,			
						procedures or special consideration)				
Address			Addres	5						
Telephone				one (ie ()					
Date of Service (D/M/Y)	Procedure Code	Intl. Tooth Coc	le Toot	h Surfaces	Dentist's Fees	1	Laboratory Total Charges			
						_				
This is an acc payable, E & 0	urate statement of DE.	services perfor	med and t	he total fee	e due and	Tot \$	Total Fee Submitted : \$			
5. DENTIS	ST'S SUPPLEM	ENTARY RE	PORT							
5.1. Description of damage										
5.2. 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)										
5.3. Describe	further potential pr	oblems and inc	licate time	frame.						
5.4. 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? Questions B; C; D and E are before accident								e accident		
F) If not	whole or sound te	eth, explain rea	son why							
Dentist's Si	gnature							Date D	M Y	
6. REMIT	PAYMENT TO F			(T)			· · · · · · · · · · · · · · · · · · ·			
		ROVIDER	onybon			-		be made payable to the Pr		
I hereby assigr not to exceed t	he charge for the s	ervices describ				io ine		si anu aunonze payme	ent directly to him/her, but	
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.										
		aonno meage ti			13 accu			charged to me for Serv	ioco rendered.	
Signature of patient (or parent / guardian)							D M Date	Y () phone	
Signature		and guardiarity					Dale	Tele		