



PROOF OF LOSS
ACCIDENTAL MEDICAL
SPORTS INSURANCE

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

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 the following address:

1225 St-Charles Street West, Bureau 200, Longueuil QC J4K 0B9

Insured Statement Section

Policy Number: _____

1. Insured Member's Full Name _____

2. Date of Birth D M Y 3. If a Minor, give Full Name of Parent or Guardian _____

4. What is your occupation outside of your sports activities? _____

5. Employer _____

Address Street City Province Postal Code

6. Name of Team for which you were playing _____ 7. Type of Sport _____

8. Date of Accident D M Y 9. Date first treated by doctor D M Y

10. Where did accident occur? _____

11. Was it during an approved [] practice [] game [] travelling If travelling, please provide the following:

Date of departure from prov. of residence D M Y Date of return to prov. of residence D M Y

12. Describe injury _____

13. Describe fully how accident occurred _____

14. Full Name of Physician who first treated you _____

Address Street City Province Postal Code

15. Full Name(s) and address(es) of other doctor(s) who treated you _____

16. Name of hospital if treated in hospital _____

17. Date treated in hospital D M Y

18. Do you have any other Hospital or Medical Insurance? [] Yes [] No Plan Name/Policy Number _____

I certify to the best of my knowledge that the statements made above are true, correct and complete.

Injured Member's Signature (or Signature of Parent or Guardian if injured member is a minor) Telephone Date

Complete Address Street City Province Postal Code

Please return completed claim form with the "Consent to collect, use and disclose personal information" form.

Club Section

1. Name of Team _____ 2. Policy Number _____

3. Name of League or Association _____

4. What sport is team engaged in _____ 5. On what date did player join the team D M Y

6. Was the above player a regular member at the time of injury [] Yes [] No

7. Was the player injured during an approved activity? [] Yes [] No If yes, an approved [] practice [] game [] travelling

Authorized Signature Print Name Official Position/Title

Complete Address Street City Province Postal Code

Telephone () Date D M Y

Attending Physician Statement Section

Page 2

Policy Number _____

1. Patient's Name _____ 2. Patient's Age _____
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? _____

Physician's Name (Print) _____ Physician's Signature _____

Address _____
 Street City Province Postal Code

Telephone () _____ Date D M Y

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