

**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 any of the following addresses:

**SSQ Place, 110 Sheppard Avenue East, Suite 500,  
Toronto, Ontario M2N 6Y8  
2020 University Street, Suite 1800, Montreal, Quebec H3A 2A5  
800 - 6th Avenue S.W., suite 650, Calgary, Alberta T2P 3G3**

Emailed, faxed or photocopied forms (once completed) are unacceptable for claims purposes.

**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.*