SSQ Financial Group

PROOF OF LOSS
ACCIDENTAL DENTAL (SPORTS INSURANCE)

SSQ Insurance Company Inc.

RESET

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

Instructions - Insured member - complete Claimant's Statement; Team Manager or Administrator -complete Club Section at bottom of page 1. Attending Dentist - complete Dental Section on page 2.

Important - 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 the Dental plan. If there is any unpaid balance, please attach their payment statement(s).

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 to **SSQ Insurance Company Inc.** at any of the following addresses:

SSQ Place, 110 Sheppard Ave East, Suite 500, Toronto, Ontario M2N 6Y8
2020 University Street, Suite 1800, Montreal, Quebec H3A 25A
800 - 6th Avenue S.W., suite 650, Calgary, Alberta T2P 3G3

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

Claimant's Statement

Policy Number 1HB80

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 your sports activities? _____

5. Name of Employer _____

Address _____
Number & 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. Where did accident occur? _____

10. Describe in detail how accident occurred _____

11. Was it during an approved: ☐ practice ☐ game ☐ travelling 12. Where was practice or game taking place? _____

13. Date first treated by dentist D M Y

14. Name of Dentist _____

Address _____
Number & Street City Province Postal Code

15. Name(s) of other dentist(s) who treated you _____

16. If treated in hospital, Name of Hospital _____ 17. Date treated D M Y

18. Do you have coverage for any dental expenses under any other Hospital, Medical or Dental Plan? ☐ Yes ☐ No

If Yes, Plan Name _____ Company _____ Policy Number _____

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

_____ ( ) D M Y
Claimant's Signature (or signature of Parent or Guardian if Claimant is a minor) Telephone Number Date

Complete Address _____
Number & Street City Province Postal Code

The furnishing of this form or its acceptance is not an admission of liability by the company or a waiver of any conditions of the policy.

Club Section

Policy Number 1HB80

1. Name of Team _____ 2. Name of League or Association _____

3. What sport is team engaged in? _____ 4. What date did player join team D M Y

5. Was the player a regular member at time of injury? ☐ Yes ☐ No

6. Was the player injured doing an approved activity? ☐ Yes ☐ No If Yes, an approved ☐ practice ☐ game ☐ travelling

_____ _____ _____
Authorized Signature Print Name Official Position/Title

Complete Address _____
Number & Street City Province Postal Code

Telephone Number ( ) Date D M Y

Proof of Loss – Accidental Dental (Sports Insurance)

Part 1 – Dentist

Policy No.: 1HB80

Unique No.	Spec.	Patient's Office Account Number
Patient's Name Address Telephone No: ( )	**Dentist's Name** Address Telephone No: ( )	I hereby assign any benefits payable from this claim to the named dentist and authorize payment directly to him/her. Signature of Subscriber

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 Amount	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

Part 2 – 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