PROOF OF LOSS
ACCIDENTAL MEDICAL (SPORTS INSURANCE)

SSQ Insurance Company Inc.
2020 University Street, Suite 1800, Montreal, Quebec H3A 2A5

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:

Exchange Tower 130 King Street West 23rd floor, Suite 2350, PO BOX 160, Toronto Ontario, M5X 1C7
2020 University Street, Suite 1800, Montreal, Quebec H3A 2A5
220 - 12th Avenue S.W., suite 600, Calgary (Alberta) T2R 0E9

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.

____________ ( ) ____________ D M Y ____
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

 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.