SSQ Financial Group

AUTHORIZATION
COLLECT, USE AND DISCLOSE PERSONAL INFORMATION

SSQ, Insurance Company Inc.

110, Sheppard Avenue East, Suite 500
Toronto (ON) • M2N 6Y8
Fax: 1-866-411-9248

800 - 6th Avenue S.W., Suite 650
Calgary (AB) • T2P 3G3
Fax : 1-866-411-9248

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

I authorize SSQ Insurance Company Inc. and its authorized representatives to collect, use, and disclose personal information about me and, where applicable, my dependent children as permitted by law from and to the following persons and organizations:

- any licensed medical practitioner or licensed health professional, hospital, clinic or medically related facility;
- any other insurance company or financial institution, including any reinsurance company;
- any other person or organization with information relevant to my claim; and
- any person or organization that provides information services or insurance services to, or that acts as insurance intermediary for SSQ Insurance Company Inc.;

For the following purposes:

- establishing and maintaining communications with me;
- underwriting group risks on a prudent basis;
- investigating and settling claims;
- detecting and preventing fraud;
- compiling insurance statistics; and
- complying with the law.

The personal information collected by SSQ Insurance Company Inc. will be entered into a file whose subject is accident and sickness insurance. The file will be kept at SSQ Insurance Company Inc. offices. Within SSQ Insurance Company Inc., this file will only be accessed by those employees who require access in order to fulfill the purposes listed above. I understand that I may access my personal information contained in this file and correct such information if necessary by directing a written request to:

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

This consent shall be valid for the length of time necessary for SSQ Insurance Company Inc. to achieve the purposes listed above. I may withdraw this consent at any time by giving SSQ Insurance Company Inc. written notice of withdrawal. I understand that withdrawal of my consent might result in SSQ Insurance Company Inc. being unable to provide me with a product or service.

A copy of this consent shall be considered as effective and valid as the original.

POLICY NO.	CERTIFICATE NO. (if known)

DATE OF THE OCCURENCE	CAUSE (ACCIDENT, ILLNESS, ETC.)
SIGNATURE OF INSURED X	DATE OF SIGNATURE
PRINT NAME OF INSURED	TELEPHONE NUMBER
ADDRESS	

Where the claim is for the Accidental Death of the Insured Person, this consent must be signed by their authorized representative, and shall apply to both the Insured Person and the authorized representative:

SIGNATURE OF AUTHORIZED REPRESENTATIVE X	DATE OF SIGNATURE
PRINT NAME OF AUTHORIZED REPRESENTATIVE	RELATIONSHIP TO THE INSURED

SSQ Financial Group

Emergency medical claim report
OUT-OF-PROVINCE / OUT-OF-COUNTRY

SSSQ Financial Group, 1225 St-Charles Street West, Suite 200, Longueuil QC J4K 0B9
claims.spgroup@ssq.ca

1. Statement of Participant

1.1 **Policy No.**: _____ 1.2 **Certificat No.** (if known): _____

1.3 Participant Name: _____ _____ 1.4 Date of Birth: |__|__|__|__|__|__|__|__|
First Name Last Name

1.5 Is the participant retired? ☐ Yes ☐ No

1.6 Address: _____ _____ _____ |__|__|__|__|__|__|
Street City Province/Country Postal Code

1.7 Email: _____

To be completed by the Participant who is claiming for his/her dependent children. (Please complete one claim form per child).

1.8 Dependent Name	Relationship to Participant	Date of Birth

Claimant Signature (if over 18 years old): _____

1.9 Does he/she permanently reside with you? ☐ Yes ☐ No Is your dependent child married? ☐ Yes ☐ No

Is he/she in attendance at University or College? ☐ Yes ☐ No

If "Yes", give name and address of school.

_____

1.10 Is the claimant insured under a provincial health plan? ☐ Yes ☐ No If "No", please provide an explanation.

_____

1.11 Does the claimant have any other health insurance? ☐ Yes ☐ No If "Yes", please give name and address of company.

_____

Policy Number: _____ Type of Coverage: _____

1.12 Employer's Name: _____ 10. Telephone No.: _____

1.13 Employer's Address: _____

2. Authorization

I agree that the information provided on this form is complete and accurate. I understand that the information provided by me to SSQ about myself and my dependents, will be used by SSQ for claims adjudication and any other services necessary in the administration of our benefits which may include the exchange of information with other parties to administer this benefit claim. I authorize release of the information contained in this claim form to my insuring company / plan administrator. I am authorized by my spouse and/or dependent children affected by this claim to disclose and receive information about them.

_____ |__|__|__|__|__|__|__|__| _____
Signature of Participant Date Telephone Number

3. Direct deposit

Please provide the following information if you would like your claim payment deposited to a **Canadian** bank account. Please attach a "Void" cheque.

_____ _____ _____
Bank # Transit # Account #

4. Claim Details

4.1 Was this expense incurred while travelling on business? ☐ Yes ☐ No

4.2 Departure date from province: └┴┴┘└┴┘└┴┘ 4.3 Return date to province: └┴┴┘└┴┘└┴┘

4.4 This claim is due to: ☐ Injury ☐ Sickness Describe how and where it happened:

_____

_____

4.5 When did injury occur or symptoms of sickness first appear? └┴┴┘└┴┘└┴┘

4.6 Where did injury occur or symptoms of sickness were first noted (city/country)? _____

4.7 Have you had same or similar condition before? ☐ Yes ☐ No If yes, when? _____

If "Yes", provide details.

_____

_____

4.8 Were you hospitalized for your present condition? ☐ Yes ☐ No If "Yes", please provide the following:

Name and address of hospital: _____

Dates of hospital confinement:

From └┴┴┘└┴┘└┴┘ to └┴┴┘└┴┘└┴┘ | From └┴┴┘└┴┘└┴┘ to └┴┴┘└┴┘└┴┘

4.9 Name and address of your family doctor in Canada.

Name: _____ Telephone: _____

Address: _____

5. Schedule of Expenses (if space is insufficient, please continue on a separate sheet of paper)

Important – Send original copy of receipts or invoice (Keep copies for personal records. Originals will not be returned.)

Date of Service	Claimed services	Name of Provider	Total Bill*	Country and Currency	Has Account Been Paid? Yes	No	Paid By Provincial Health Plan	Paid by Other Insurance Carrier
					☐	☐		
					☐	☐		
					☐	☐		
					☐	☐		
					☐	☐		
					☐	☐		
					☐	☐		
					☐	☐		
					☐	☐		
		Totals						

6. Remit payment to provider (To be completed by the participant if cheque is to be made payable to the Provider)

I hereby assign to _____ benefits payable to me, but not to exceed the charge for the services described on this claim form. I understand that I am financially responsible for charges not covered by this assignment. I certify to the best of my knowledge that the statements made are true, correct and complete.

_____ └┴┴┘└┴┘└┴┘ _____

Signature of Participant Date Telephone Number

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AUTHORIZATION
DIRECT DEPOSIT

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1. PARTICIPANT IDENTIFICATION

Policy Number _____ **Claim Number** _____

Insured's Name _____ Telephone No. ( ) _____

Address _____

Number & Street City Province Postal Code

2. BANK INFORMATION

Name of Financial Institution _____

Address of Financial Institution _____

Number & Street City Province Postal Code

Type of Account:
- ☐ Chequing *(please attach a **void** cheque)*
- ☐ Savings *(please provide your banking information below)*

_____ _____ _____

Transit/Branch No. Institution No. Account No.

Note: Your banking information appears on the bottom of your cheque as per example below:

⑈'000 ⑈" ⑆- 01234 ⑆ 001 ⑆ ⑆ 12345679 ⑆⑈

↓ Transit # ↓ Institution # ↓ Account #

3. AUTHORIZATION

I authorize SSQ Insurance Company Inc. to deposit my claim benefit payments to the account mentioned on this form.

Insured's Signature _____ Date D M Y

Account Holder Signature (if other than Insured) _____ Date D M Y