To assist you in preparing for any future <u>out-of-province</u> <u>medical referral</u> claims, we are providing you with a list of steps that must be followed prior to seeking reimbursement from SSQ Insurance Co. Inc. You must have:

- 1. A written referral from the attending physician. The referral must state:
 - a. the diagnosis
 - b. the service is not available in New Brunswick
 - c. if a travel companion is needed
 - d. if follow-up medical travel is expected

Maximum Eligible Expense:

- a. Economy Airfare OR \$.29 Km for mileage
- b. Up to \$100.00 per day for meals, lodging, parking and ground transportation
- c. Must submit itemized paid-in-full receipts
- d. Confirmation of appointment attendance.

When submitting claims to SSQ Insurance Co., Inc.:

- a. Complete a to Collect, Use and Disclose Personal Information (Consent) form and forward the written doctor's referral, confirmation of appointment, # of kilometres if driving, and all <u>paid-in-full</u> receipts to: SSQ Insurance Co. Inc., 1225 St-Charles St. West, Suite 200, Longueuil, Quebec J4K 0B9
- b. State your UNB Group SSQ Travel Policy Number (1L915), ID number (427E) and indicate who the claim is pertaining to (ie. plan member, spouse and/or dependent if applicable)
- c. State this is a "referral claim". Indicate which dates you travelled and/or where you were hospitalized out-of-province or attended a clinic appointment.

Please make sure your address is kept up-to-date with UNB Human Resources as the reimbursement cheques will be sent to your home address if you don't provide a banking information for direct depoit.

IF YOU NEED ASSSITANCE OR HAVE CONCERNS ONCE THE CLAIM HAS BEEN PROCESSED, PLEASE CONTACT UNB HUMAN RESOURCES, 453-4648, ATTENTION SHERRI ROBICHAUD.



University of New Brunswick: Out-of-Province Referral Request Letter

Instructions:

Please ensure the following documents are attached to this letter:

1 An Attending Physician's referral

2 Confirmation of appointment – letter or note from attending physician

3. The receipts and notification of mileage

4 Please complete the Emergency Medical Claim Report, Consent to Collect form, and return it along with your receipts to the address noted below

Note: all claim forms are available on the University of New Brunswick's website

Policy Number:

1L915

SSQ Insurance Company Inc. agrees this letter is to be used for the adjudication of Out-of-Province Travel claims in the interim of establishing an Out-of-Province Referral Claim Form Claims are to be adjudicated according to the Referral Services Outside of the Insured Person's Province of residence or Canada section of the policy noted above. Please note the following unique contract wording specific to the University of New Brunswick:

Travel Expenses – Charges for travel expenses along a normal and reasonable route, without delay or stop-over, of an Insured Person, parent, guardian or family member while accompanying the Insured Person for treatment outside their province of residence but while still remaining in Canada are considered as follows:

- Up to \$100 per day per Insured Person as an outpatient while receiving recommended medical treatment outside
 of their province of residence
- Up to \$100 per day for a parent, guardian or family member who accompanies the Insured Person.
- Economy class airfare or if transportation occurs in a vehicle or device other than one operated under a license
 for hire, then reimbursement of transportation expenses will be limited to a maximum of \$0.29 per km for travel to
 and from the recommended place of medical services.

Please retain copies and mail originals to:

Group Insurance Claims - Accident & Illness

SSQ Financial Group Billing and Enrolment 1225 St-Charles St. West, Suite 200 Longueuil, QC J4K 0B9



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. Statem	ent of Participant				
1.1 Policy I	No.:	1.2 Certificat No. (if kn	own):		
1.3 Participa	ant Name:			1.4 Date of Birth:	
1 F Jatha na	First Name	Last Nar	ne		
1.5 Is the pa	articipant retired? Yes] NO			
1.6 Address:	Ctroot			Province/Country	. Dostal Coda
1.7 Email:	Street	City		Province/Country	Postal Code
		o is claiming for his/her depe			
1.8 Depende	ent Name		Rela	tionship to Participant	Date of Birth
					granis, oto, o
Claimant	: Signature (if over 18 years old	i):			
	she permanently reside with yo				
	in attendance at University or		,		
	give name and address of scho	3			
1.11 Does the	claimant have any other health	n insurance?	If "Yes", please give name	e and address of company.	
Policy Nu	mber:	Type of Coverage			
1.12 Employer	's Name:		10.	Telephone No.:	
1.13 Employer	's Address:				
2. Authoriz				ment replacement of the residency of the residency of the residency of the Color of	umber het Produktion (in Principal in State and in State (in State and in State and in State (in State and in Principal in State and in
will be used by other parties t	SSQ for claims adjudication and administer this benefit claim.	orm is complete and accurate. I un id any other services necessary in t . I authorize release of the inform hildren affected by this claim to di	he administration of our beneation contained in this claim	efits which may include the excl form to my insuring company	hange of information with
Signature of Pa	articipant	v v	Date	Telephone Numb	per
3. Direct de	eposit	aan amaaanaa maa waxaa uu oo			erandam ortherandenne ortherand vortendad a trongen a decensive a tropic tradition
		ou would like your claim payment	deposited to a Canadian ba	nk account. Please attach a "Ve	oid" cheque.
Bank #		 Transit #		Account #	

4.	Claim Details		Characteristics of American September 1 Se		name industripe on introduced to insight embersion		Washington and south		ani ati i dililingan odon u ruyy yo na Produciji (Pri Aragan u ni Abert	
4.1	Was this expense incur	red while travelling on b	usiness? 🗌 Yes 🔲 No							
4.2	Departure date from pr	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 of	or symptoms of sickness	first appear?	1 1 1 1 1 1						
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?									
	If "Yes", provide details.									
4.8	Were you hospitalized for	or your present condition	n? □ Yes □ No	If "Yes", please	provide the follow	wing:				
	Name and address of hospital:									
	Dates of hospital confine	Dates of hospital confinement:								
	From	to L		From L			∐ to	لتبييا		
4.9	Name and address of yo	our family doctor in Cana	da.							
	Name:	Name: Telephone:								
	Address:									
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	Date of Service	Claimed services	Name of Provider	Total Bill*	Country and Currency		Paid?	Paid By Provincial Health Plan	Paid by Other Insurance Carrier	
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Signa	ture of Participant			Date			Telephor	ne Number	FAS202A (2016-06)	



AUTHORIZATION

DIRECT DEPOSIT

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: 1-355-690-9895 Email : claims.spgroup@ssq.ca

1. PARTICIPANT IDE	ENTIFICATION							
Policy Number		Claim Number						
Insured's Name		Telephone No. ()						
Address								
Number & S	Street		City		Province	Po	ostal Code	
2. BANK INFORMAT	ION							
Name of Financial In	estitution					10 A 5 A 5 A 5 A 5 A 5 A 5 A 5 A 5 A 5 A		
Address of Financial Institution								
	Number & Street		City		Province	P	ostal Code	
Type of Account: Chequing (please attach a void cheque) Savings (please provide your banking information below)								
	Transit/Branch No.	ansit/Branch No. Institution No.			Account No.			
	Note: Your banking information appears on the bottom of your cheque as p					er example below:		
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3. AUTHORIZATION		500. 412640492656990564906	Control de Marie Control de Contr			Ø.		
I authorize SSQ Inson this form.	urance Company Inc	. to deposi	t my claim ben	efit payments	s to the ac	count r	nentioned	
Insured's Signature				Date	D	M	Υ	
Account Holder Signa (if other than Insured)	ature			Date	D	M	Y	