

SECTION 1 - PARTICIPANT INFORMATION

Group No.		SSQ Certificate No.	
Last Name		First Name	
Address			
Town/City	Province	Postal Code	

SECTION 2 - DECLARATION

I declare that all attached expenses have been incurred for : Myself My spouse My dependent children (indicated below)

Is this the first declaration for any of these individuals? No Yes, complete section 3

Are these expenses covered under another insurance contract? No Yes, complete section 4

Are these expenses the result of an accident? No Yes, complete section 5

I want to use my Health Spending Account for the unpaid portion of my claim.

SECTION 3 - TO BE COMPLETED IF IT IS THE FIRST CLAIM FOR YOUR SPOUSE OR YOUR DEPENDENT CHILDREN

Last Name	First Name	Date of birth (YYYY-MM-DD)	Gender	Relationship with participant
			<input type="checkbox"/> F <input type="checkbox"/> M	<input type="checkbox"/> Spouse <input type="checkbox"/> Dependent child *
			<input type="checkbox"/> F <input type="checkbox"/> M	<input type="checkbox"/> Spouse <input type="checkbox"/> Dependent child *
			<input type="checkbox"/> F <input type="checkbox"/> M	<input type="checkbox"/> Spouse <input type="checkbox"/> Dependent child *

* If your child is unmarried, age between 18 and 26 and a full-time student, you must fill out a declaration of school attendance for him or her to remain eligible for insurance benefits as a dependent child. Visit our website at www.ssq.ca under ACCESS | Plan Members.

SECTION 4 - TO BE COMPLETED IF YOU HAVE SIMILAR HEALTH INSURANCE COVERAGE WITH ANOTHER INSURER

Name of policyholder _____	Name of other insurer _____	Contract Number _____
Coverage status : <input type="checkbox"/> Family <input type="checkbox"/> Individual <input type="checkbox"/> Single-Parent <input type="checkbox"/> Couple	Benefit type : <input type="checkbox"/> Drug <input type="checkbox"/> Dental Care <input type="checkbox"/> Visual Care <input type="checkbox"/> Others	

SECTION 5 - TO BE COMPLETED IF THE EXPENSES ARE THE RESULT OF AN ACCIDENT

Name of injured individual : _____

Accident date (YYYY-MM-DD) : ____/____/____

Accident type: work automobile other _____

SECTION 6 : AUTHORIZATION

I declare the above information to be complete and accurate. I understand that the information I have provided will be used by SSQ, Life Insurance Company Inc. to adjudicate my claims and that it may be shared with third parties only for the purpose of allowing them to process this claim. I am authorized by my spouse and/or dependent children affected by this claim to disclose and receive information about them.

Participant signature: _____ Date : ____/____/____

IMPORTANT

- Send original copies of receipts or invoices and keep copies for your personal records. Originals will not be returned.
- If your claim is for services from a healthcare professional (chiropractor, physiotherapist, etc.), make sure the receipt or invoice clearly states the name of the patient, the date, nature and fees for each treatment and the name of the healthcare professional, the association he or she is a member of and his or her license number.
- Make sure to organize receipts or invoices per patient.

