



**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

Page 2

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.