SSQ Financial Group

CLAIM FOR HEALTH INSURANCE BENEFITS

P.O. Box 6600, Station A, Sudbury, ON P3A 5N5; Tel: 1 888 777-8811

A. Policyholder/Participant Information

Policyholder	Group No.	Certificate No.

Participant's Last Name and First Name	Gender	Birth Date		
	☐ M ☐ F	D	M	Y

Mailing Address

Suite/Apt. No.

Town/City | Province | Postal Code

Language Preference: ☐ English ☐ French

B. Claim Information

Please complete all requested information and list expenses in date order. Use a separate line for each person and **attach original receipts**.
Incomplete forms or photocopied receipts cannot be processed for payment.

Patient's Name	Relationship to Participant	Gender	Birth Date			Is dependent child a full-time student?	Receipt Date			Description of Expense	Amount
			D	M	Y		D	M	Y		
		☐ M ☐ F				☐ Yes ☐ No					
		☐ M ☐ F				☐ Yes ☐ No					
		☐ M ☐ F				☐ Yes ☐ No					
		☐ M ☐ F				☐ Yes ☐ No					
		☐ M ☐ F				☐ Yes ☐ No					
											Total $

*If child is age 21 or over and registered as a full-time student, please indicate the name of the educational institution and the most recent date of registration.

Dependent's Name (Last, First)	Name of Educational Institution	D	M	Y

C. Coordination of Benefits

1. Are any of these expenses the result of a work-related accident? ☐ Yes ☐ No
2. Are any of these expenses payable under another insurance plan?
   ☐ Yes ☐ No If yes, name of insurance carrier: | Policy No.:
3. If other coverage was available and has recently terminated, please specify the termination date: Day _____ Month _____ Year _____

If you are claiming expenses for your spouse and your spouse is covered for those expenses under another health insurance plan, you must submit the claim to your spouse's plan first. You may then submit a claim for expenses not reimbursed by your spouse's plan to ClaimSecure, enclosing a copy of the settlement provided by the other carrier.

If both you and your spouse have health insurance coverage, your children must first claim under the plan of the parent with the earliest birthday (month and day) in the calendar year.

D. Participant's Authorization

I certify that the above information is true and complete to the best of my knowledge and that the above expenses are for goods and services that I, my spouse or my eligible dependents have received. I certify that I am authorized to disclose and receive information about my spouse and/or dependents for the purposes of assessing and paying benefits, if any. I acknowledge that unless assigned to the service provider, any reimbursement of the above expenses and explanation of amounts paid will be provided to the participant.

I understand that SSQ Financial Group shall have the right to recover from myself and/or my dependents any payments made in error or as a result of fraud, as well as any costs related directly to the recovery of such funds.

I authorize ClaimSecure, SSQ Financial Group, health care professionals, insurers, administrators of government or other benefit plans, and other service providers working with ClaimSecure and SSQ Financial Group to exchange information regarding this claim that is required for the purpose of administering my health insurance plan.

Name (Please Print) | Signature | Date Signed (dd/mm/yyyy)