

1. CLAIMANT'S STATEMENT

4.1. Policy No. _____ 4.2. Certificate No. (if known) _____

4.3. Insured Name _____ 4.4. Date of Birth D M Y
Given Name Family Name

4.5. Is the Injured Person a Canadian resident? Yes No

4.6. If Injured Person is a minor, give Full Name of Parent/Guardian _____

4.7. Address _____
Street City Province Postal Code

4.8. Email (of parent if minor) _____

4.9. Name of the School Board and District _____

4.10. Date of the accident D M Y 4.11. Place of accident _____

4.12. Describe injury _____

4.13. Describe fully how accident occurred _____

4.14. Date of first treatment D M Y 4.15. Date treated in hospital D M Y

4.16. Full Name of Physician _____ Telephone No. () _____

4.17. Name of Hospital if applicable _____

4.18. 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. I understand that the information I have provided will be used by SSQ, Insurance Compagny to adjudicate my claims and that it may be shared with third parties only for the purpose of allowing them to process this claim.

Insured Person's Signature (Parent or Guardian if injured member is a minor) _____ Date D M Y Telephone () _____

2. DIRECT DEPOSIT

Please provide the following information if you would like your claim payment deposited to a **Canadian** bank account:

Bank # _____ Transit # _____ Account # _____ **Please attach a "Void" cheque**

3. SCHOOL DECLARATION

3.1. Name of School _____

3.2. Complete Address _____
Street City Province Postal Code

3.3. Name of Administrator _____ 3.4. Official Position _____

3.5. Effective date of Student's coverage D M Y 3.6. Policy No. _____

3.7. Was the student injured during an approved activity? Yes No

School Official Signature _____ Date D M Y Telephone () _____

4. DENTIST

Policy No.: _____

Unique No.		Spec.		Patient's Office Account Number	
Patient's Name		Dentist's Name		For Dentist use only <input type="checkbox"/> Duplicate form (for additional information, diagnosis, procedures or special consideration)	
Address		Address			
Telephone	()	Telephone	()		

Date of Service (D/M/Y)	Procedure Code	Intl. Tooth Code	Tooth Surfaces	Dentist's Fees	Laboratory Charges	Total Charges

This is an accurate statement of services performed and the total fee due and payable, E & OE. **Total Fee Submitted :**
\$ _____

5. DENTIST'S SUPPLEMENTARY REPORT

5.1. Description of damage _____

5.2. Is further treatment indicated? Yes No **If Yes, please indicate :**

Intl. Tooth Code	Treatment Indicated – use procedure code if possible	Estimated Date – Treatment (D/M/Y)

5.3. Describe further potential problems and indicate time frame. _____

- 5.4. A) How many teeth were injured? _____ B) Were these whole or sound teeth? Yes No
 C) How many of these teeth had fillings? _____ D) How many of these injured teeth had crowns? _____
 E) How many of these injured teeth had root canal treatment? _____
 F) If not whole or sound teeth, explain reason why _____

Dentist's Signature _____ Date

6. REMIT PAYMENT TO PROVIDER

(To be completed by the employee if cheque is to be made payable to the Provider)

I hereby assign to _____ any benefits payable from this claim to the named dentist and authorize payment directly to him/her, but not to exceed the charge for the services described on this claim form.

I understand that the fees listed in this claim may not be covered by or may exceed my plan benefits. I understand that I am financially responsible to my dentist for the entire treatment. I acknowledge that the total fee of \$ _____ is accurate and has been charged to me for services rendered.

Signature of patient (or parent / guardian) _____ Date Telephone