

1. Statement of Participant

1.1 Policy No.: _____ **1.2 Certificate No.** (if known): _____

1.3 Participant Name: _____ 1.4 Date of Birth: | A | A | A | A | M | M | J | J |
First Name Last Name

1.5 Is the Injured Person a Canadian resident? Yes No

1.6 If Injured Person is a minor, give Full Name of Parent/Guardian: _____

1.7 Address: _____ Postal Code: | | | | | | | |
Street City Province

1.8 Email (of parent if minor): _____

1.9 Name of the School Board and District: _____

1.10 Accident Description

- a) Date of the accident: | Y | Y | Y | Y | M | M | D | D | b) Place of accident: _____
- c) Describe injury: _____
- d) Describe fully how accident occurred: _____

1.11 Health Treatment

- a) Date of first treatment: | Y | Y | Y | Y | M | M | D | D | b) Date treated in hospital: | Y | Y | Y | Y | M | M | D | D |
- c) Full Name of Physician: _____ Telephone: _____
- d) Name of Hospital if applicable: _____

1.12 Do you have any other Hospital or Medical Insurance? Yes No

Plan Name/Policy Number: _____

I agree that the information provided on this form is complete and accurate. I understand that the information provided by me to SSQ about myself and my dependents, will be used by SSQ for claims adjudication and any other services necessary in the administration of our benefits which may include the exchange of information with other parties to administer this benefit claim. I authorize release of the information contained in this claim form to my insuring company / plan administrator. I am authorized by my spouse and/or dependent children affected by this claim to disclose and receive information about them.

Signature (Parent or Guardian if injured member is a minor) Date Telephone

2. Direct Deposit

Please provide the following information if you would like your claim payment deposited to a bank account. **Please attach a "Void" cheque**

Bank # Transit # Account #

3. School Declaration

3.1. Name of School: _____

3.2. Complete Address: _____ Postal Code: | | | | | | | |
Street City Province

3.3. Name of Administrator: _____ 3.4. Official Position: _____

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

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

School Official Signature Date Telephone

4. Attending Physician Statement Section

4.1. Patient's Name: _____ 4.2. Patient's Date of Birth: | Y | Y | Y | Y | M | M | D | D |

4.3. Diagnosis of present condition: _____

a) Primary: _____

b) Secondary (if applicable): _____

4.4. On what dates did you examine the patient? | Y | Y | Y | Y | M | M | D | D | | | Y | Y | Y | Y | M | M | D | D | | | Y | Y | Y | Y | M | M | D | D |

4.5. To the best of my knowledge:

a) Symptoms first appeared or accident happened? | Y | Y | Y | Y | M | M | D | D |

b) Patient has had same or similar condition? Yes No

If "Yes", state particulars: _____

4.6. If attended at hospital, name of hospital: _____

Admitted: | Y | Y | Y | Y | M | M | D | D | Time: _____ Discharged: | Y | Y | Y | Y | M | M | D | D | Time: _____

4.7. If surgery performed, describe: _____

4.8. If patient referred to you, give name of referring physician: _____

4.9. Have you referred the patient to a specialist for additional treatments Yes No

If "Yes", please explain: _____

4.10. Have you referred the patient for physiotherapy treatments? Yes No If yes, date such referral was made: | Y | Y | Y | Y | M | M | D | D |

Frequency and duration of physiotherapy treatments? _____

4.11. To the best of my knowledge, the patient has been totally disabled (unable to attend school)

From | Y | Y | Y | Y | M | M | D | D | to | Y | Y | Y | Y | M | M | D | D | inclusive

4.12. If still disabled, what date should the patient be able to return to school? | Y | Y | Y | Y | M | M | D | D |

Or, if indefinite, what is the estimated number of weeks before such return _____ additional weeks.

How long was or will the patient be partially disabled (able to attend part-time school)?

From | Y | Y | Y | Y | M | M | D | D | to | Y | Y | Y | Y | M | M | D | D | inclusive

Physician's Name (Print): _____

License Number: _____ General Practitioner Specialist Specify: _____

Address: _____ Street _____ City _____ Province _____ Postal Code: | | | | | | | |

Telephone: _____ Fax: _____

Signature _____ Date | Y | Y | Y | Y | M | M | D | D |

The patient is responsible for securing this form and for any charges made for its completion.