

**CLAIMS PROCEDURE**

**REVERSE SIDE MUST BE COMPLETED BY DOCTOR/DENTIST ON ALL INJURY CLAIMS.**

**IMPORTANT: Please attach original receipts for all eligible expenses. Completed claim form must be filed with SSQ, Life Insurance Company Inc. within 90 days after the date of the injury, and no later than 1 year, regardless of whether expenses have been incurred.**

Mail to: SSQ, Life Insurance Company Inc., Claims Department, Suite 500, 110 Sheppard Avenue East, Toronto, Ontario M2N 6Y8  
Toll Free: 1-866-696-6001

**Student Information**

Full Name of Student \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Surname \_\_\_\_\_ First Name \_\_\_\_\_ Initial \_\_\_\_\_ Sex  M  F  
( D D / M M / Y Y Y Y )

Home Address \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ Province \_\_\_\_\_ Postal Code \_\_\_\_\_

Current Mailing Address (If different from above) \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ Province \_\_\_\_\_ Postal Code \_\_\_\_\_

Name of Parent or Guardian \_\_\_\_\_

Group Policy Number \_\_\_\_\_ Name of Post-Secondary Institute \_\_\_\_\_

**Accident Information**

Date of Accident \_\_\_\_\_ Time of Accident \_\_\_\_\_ Where did accident occur \_\_\_\_\_  
( D D / M M / Y Y Y Y ) A.M.  P.M.

Please explain, in **detail**, how accident happened (If you require more space attach a separate sheet of paper, signed and dated):

What injuries were caused by accident? \_\_\_\_\_ Under whose immediate supervision was student at time of accident? \_\_\_\_\_

**Treatment Received**

On what date did you first consult Physician or Dentist? \_\_\_\_\_ Name and Address of Physician or Dentist \_\_\_\_\_  
( D D / M M / Y Y Y Y )

Are any benefits or services provided under any other group insurance or plan? \_\_\_\_\_ Name of Insuring Company \_\_\_\_\_  
Yes  No

**Authorization and Declaration**

I hereby CERTIFY that the information contained in this Claim Form is true and complete to the best of my knowledge.  
On behalf of myself and/or any minor insured, I RELEASE the information contained in this Claim Form to Industrial Alliance Pacific Insurance and Financial Services Inc. ("IAP") and ACKNOWLEDGE that this information will be used to assess, process and administer this claim and policy coverage. I AUTHORIZE any health care provider, insurance company, school or school board, employer, or other person or other organization to disclose to IAP any medical information, information regarding charges, or other information that IAP may need in their assessment of this claim.  
I AUTHORIZE IAP to exchange the information detailed in this Claim Form and other information contained in files related to this claim or coverage with any of the parties identified in the previous paragraph for the purposes listed above, or as authorized by me, or as legally required.

Dated this \_\_\_\_\_ of \_\_\_\_\_ Year \_\_\_\_\_ Claimant: \_\_\_\_\_  
DAY MONTH YEAR (4 DIGITS) Signature

**Statement of School Authority**

Name of Student \_\_\_\_\_  
Policy No. \_\_\_\_\_ Reg. No. \_\_\_\_\_ Name of Group \_\_\_\_\_

On the date of the accident, we certify that the above claimant was enrolled as a:

Full time student (3 or more courses)  Part Time student

Signed: \_\_\_\_\_ Date Signed \_\_\_\_\_  
Signature of Person Authorized by Policyholder ( D D / M M / Y Y Y Y )

**The Claimant is responsible for securing this form and for charges incurred for its completion.**

