SSQ Financial Group

Dental Care Insurance Benefit Claim

P.O. Box 10500, Station Sainte-Foy, Quebec, Quebec G1V 4H6

Patient

Last Name:

First Name:

Address: Apt.:

Town/City: Province:

Postal Code: Telephone:

Dentist

Name:

Address:

Town/City: Province:

Postal Code: Telephone:

Unique No.:

DATE OF SERVICE Y	M	D	INT'L. TOOTH CODE	PROCEDURE CODE	TOOTH SURFACES	LABORATORY CHARGE	DENTIST'S FEE	TOTAL FEES CLAIMED

THIS IS AN ACCURATE DESCRIPTION OF THE TREATMENT PROVIDED AT THE DATE OF SERVICE INDICATED (OR TO BE PROVIDED IN THE CASE OF A TREATMENT PLAN) AND OF THE CORRESPONDING FEES CHARGED AND PAID.

TOTAL FEES CHARGED: ▶

TOTAL FEES PAID BY THE PATIENT: ▶

DATE Y M D

DENTIST'S SIGNATURE

FOR DENTIST'S USE ONLY TO INCLUDE ADDITIONAL INFORMATION (USE BACK OF FORM IF NECESSARY).

FOR SSQ USE ONLY

COMPLETED BY: DATE:

A) TO BE COMPLETED BY THE PARTICIPANT

1. a) PATIENT'S RELATIONSHIP TO PARTICIPANT:

PATIENT'S DATE OF BIRTH Y M D

b) FOR AN OVERAGE DEPENDENT, INDICATE IF UNMARRIED AND A FULL-TIME STUDENT: ☐ NO ☐ YES

c) NAME OF SCHOOL:

2. a) IS THIS TREATMENT COVERED UNDER ANY OTHER INSURANCE PLAN? ☐ NO ☐ YES

b) IF «YES», NAME OF THE COMPANY AND POLICY NUMBER:

3. IS THIS TREATMENT REQUIRED DUE TO AN ACCIDENT? ☐ NO ☐ YES

IF «YES,» COMPLETE BACK OF FORM

4. IF CLAIM IS FOR DENTURES, CROWN OR BRIDGE, IS THIS AN INITIAL PLACEMENT? ☐ NO ☐ YES

IF «NO», GIVE DATE OF PRIOR PLACEMENT AND REASON FOR REPLACEMENT: Y M D

CONTRACT NO. — CERTIFICATE NO.

PARTICIPANT'S LAST NAME

PARTICIPANT'S FIRST NAME(S)

ADDRESS

POSTAL CODE

I UNDERSTAND THAT THE FEES INDICATED IN THIS CLAIM MAY NOT BE COVERED BY, OR MAY EXCEED, MY PLAN BENEFITS. I ACKNOWLEDGE THAT THE TOTAL FEES AND THE DATES OF SERVICE INDICATED IN THIS FORM ARE ACCURATE AND THAT I WAS CHARGED FOR AND HAVE PAID THE TOTAL FEES SPECIFIED. I AUTHORIZE RELEASE OF THE INFORMATION CONTAINED IN THIS CLAIM FORM TO MY INSURER, SSQ, LIFE INSURANCE COMPANY INC., AND ITS AGENTS. I ALSO AUTHORIZE MY INSURER, SSQ LIFE INSURANCE COMPANY INC., AND ITS AGENTS, TO DISCLOSE ANY INFORMATION CONTAINED IN THIS FORM AS REQUIRED FOR THE EXAMINATION AND ADMINISTRATION OF THIS CLAIM.

SIGNATURE OF PATIENT (OR PARENT/LEGAL GUARDIAN) DATE Y M D

I CERTIFY THAT THIS INFORMATION IS TRUE, ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

PARTICIPANT'S SIGNATURE DATE Y M D

DENTAL TREATMENT REQUIRED FOLLOWING ACCIDENTAL INJURY TO NATURAL TEETH

TO BE COMPLETED BY THE PARTICIPANT

Date of accident: Y M D

Please provide exact details of where and how the accident happened:

TO BE COMPLETED BY THE DENTIST

Please specify the teeth damaged during the accident:

Were these teeth healthy prior to the accident?

☐ Yes ☐ No If not, please give details:

Please describe the condition of the teeth after the accident:

Please specify the treatment planned in relation to this accident (enclose an estimate):

Important: To facilitate claims processing, please also enclose x-rays taken **before** and **after** the accident.

X-rays will only be returned on request.