

A. Policyholder/Participant Information			
Policyholder	Group No.	Certificate No.	
Participant's Last Name and First Name			Gender <input type="checkbox"/> M <input type="checkbox"/> F
Mailing Address			Birth Date D      M      Y
Suite/Apt. No.			
Town/City		Province	Postal Code
Language Preference: <input type="checkbox"/> English <input type="checkbox"/> French			

B. Claim Information											
Please complete all requested information and list expenses in date order. Use a separate line for each person and <b>attach original receipts</b> . Incomplete forms or photocopied receipts cannot be processed for payment.											
Patient's Name	Relationship to Participant	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Birth Date			Is dependent child a full-time student? <input type="checkbox"/> Yes <input type="checkbox"/> No	Receipt Date			Description of Expense	Amount
			D	M	Y		D	M	Y		
		<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No					
		<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No					
		<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No					
		<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No					
		<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	
2. Are any of these expenses payable under another insurance plan? <input type="checkbox"/> Yes <input type="checkbox"/> 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		
<p><b>I certify</b> 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.</p> <p><b>I understand</b> 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.</p> <p><b>I authorize</b> 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.</p>		
_____ Name (Please Print)	_____ Signature	_____ Date Signed (dd/mm/yyyy)