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| ssq_fr_noir_Word | PREUVE DU SINISTRE  SOINS DENTAIRES EN CAS D’ACCIDENT DU SPORT  SSQ, Société d’assurance inc. |

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| Bien répondre à toutes les questions, c’est nous aider à mieux vous servir.  **Directives.** L’assuré doit remplir la « Déclaration du demandeur », le gérant de l’équipe ou l’administrateur, la « Déclaration du responsable du club » et le dentiste traitant, la partie lui étant réservée à la page 2.  **Important.** L’assuré doit tout d’abord envoyer sa demande à l’assureur de tout autre régime d’assurance maladie complémentaire ou d’assurance soins dentaires; si les frais ne sont pas remboursés intégralement, il fait alors parvenir à SSQ, Société d’assurance inc. tous les Relevés de prestations. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Nota –** Vous pouvez remplir le formulaireau stylo (en majuscules). Il faut cependant que TOUTES les parties signent et datent l'ORIGINAL avant que vous ne l'envoyiez à l’un des bureaux suivants de **SSQ, Société d’assurance inc. :**  1225 rue Saint-Charles ouest, Bureau 200, Longueuil QC J4K 0B9  SSQ Place, 110, avenue Sheppard est, bureau 500, Toronto (Ontario) M2N 6Y8  **800 - 6th Avenue S.W., suite 650, Calgary (Alberta) T2P 3G3** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Déclaration du demandeur | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Police no | | | | | | | | | | | | |  | | | | | | | | | | | | | | |
| 1. Nom et prénom de l’assuré | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 2. Date de naissance | | | | | | | | | | | | | | | | | | | | J    M    A | | | | | | |
| 3. S’il s’agit d’un mineur, nom et prénom d’un des parents ou du tuteur | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 4. Profession du demandeur, outre ses activités sportives | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5. Employeur | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | | | | | | | | | Rue Ville Province Code postal | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 6. Nom de l’équipe | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 7. Sport | | | | | | | | | | | |  | | | | | | |
| 8. Date de l’accident | | | | | | | | | | | | | | | J    M    A | | | | | | | | | | | | | | | | 9. Lieu de l’accident | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10. Description précise de l’accident | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 11. L’accident s’est produit pendant une  pratique, une  partie ou un  déplacement autorisés | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 12. Lieu de l'activité | | | | | | | | | | | | | | | |  | | | | | | |
| 13. Date des premiers soins dentaires | | | | | | | | | | | | | | | | | | | | | | | J    M    A | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. Dentiste traitant | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | | | | | | | Rue Ville Province Code postal | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 15. Nom de tous les autres dentistes traitants | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |  | | | | | | | | | | | | | | | | | | | | | |  | | |  | | | | | | | | |
| 16. Nom de l’hôpital, s’il y a lieu | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 17. Date de l’hospitalisation | | | | | | | | | | | | | | | | | | | | | | | J    M    A | | | | | | |
| 18. Autres assurances soins dentaires, peu importe le régime  Oui  Non | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | |
| Nom du régime | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | Assureur | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Police no | | | | | | | |  | | |
| **J’atteste que, à ma connaissance, les renseignements précédents sont exacts et complets.** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Signature du demandeur ou, s’il est mineur, d’un des parents ou du tuteur | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | Téléphone | | | | | | | | | | | | | | | | | | | |  | | Date | | | | | | |
| Adresse | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | Rue Ville Province Code postal | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| *L’envoi ou la réception du présent formulaire n’engage en rien SSQ, Société d’assurance inc. ni ne peut entraîner la dérogation à l’une des conditions contractuelles.* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Déclaration du responsable du club | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Police no | | | | | | | | | | | | | | | | | | | | |  | | | | | | |
| 1. Nom de l’équipe | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 2. Nom de la ligue ou de l’association | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | |
| 3. Sport | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 4. Date à laquelle le joueur s’est joint à l’équipe | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | J    M    A | | | | | | |
| 5. Jouait-il de façon régulière au moment de l’accident?  Oui  Non | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 6. La blessure s’est-elle produite pendant une activité autorisée?  Oui  Non | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Dans l’affirmative, il s’agit d’une  pratique, d’une  partie ou d’un  déplacement autorisés | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Signataire autorisé | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | Nom (en majuscules) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | Titre ou poste officiel | | | | | | | | | | |
| Adresse | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | Rue Ville Province Code postal | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Téléphone | | | | | | | | (     ) | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Date | | | | | | | | | | | | | | | | | | | J    M    A | | | | | | |
| Preuve du sinistre – soins dentaires en cas d’accident du sport | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Page 2 | | | | | | | | | |
| 1re partie – Dentiste | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Police no** | | | | | | | | | | | |  | | | | | |
| No unique | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Spéc. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Dossier du patient no | | | | | | | | | | | | | | | | | |
| Nom du patient   Adresse | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Nom du dentiste   Adresse | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Je cède au dentiste nommé dans la présente les indemnités payables en vertu de cette demande et je consens à ce qu’elles lui soient versées directement.  Signature du participant | | | | | | | | | | | | | | | | | |
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| Téléphone | | | | | | | | (     ) | | | | | | | | | | | | | | | | | | | | | | | | | | | Téléphone | | | | | | | | | | | | (     ) | | | | | | | | | | | | | | | | | | | | | | |
| Réservé au dentiste  Duplicata (renseignements complémentaires sur le diagnostic  ou les actes ou autres considérations particulières) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Il se peut que les frais indiqués sur cette demande ne soient pas couverts par le régime auquel je participe ou qu’ils ne soient couverts qu’en partie. Il m’incombe donc de voir à  ce que mon dentiste soit rémunéré pour tous les soins rendus. Je reconnais que le total des honoraires s’élève à       $, que ce montant est exact et qu’il m’a été facturé pour les soins reçus. Je consens à ce que tous les renseignements contenus dans la présente demande soient divulgués à l’assureur ou à l’administrateur du régime.  Signature du patient, d’un parent ou du tuteur  Vérification | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Date du traitement (J-M-A) | | | | | | | | Code de l’acte | | | | | | | | | Code int. des dents | | | Surface des dents | | | | | | | | Honoraires du dentiste | | | | | | | | | | | | | | | Frais de laboratoire | | | | | | | | | | | | | | **Total des frais** | | | | | | | Montant admis | | | | | | | | | | | Fréq. | | | | | | | | | | % | | | Montant payable par le patient |
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| La présente est une déclaration exacte des soins rendus et des honoraires demandés, sauf erreurs ou omissions. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Total des honoraires demandés       $ | | | | | | | | | | | | | | | | | | | | | | | | | | Demande d’indemnisation no | | | | | | | | | | | | | | | | | | | | | | | | |
| **2e partie – Déclaration complémentaire du dentiste** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. | | | | | Quelle est la nature des dommages? | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 2. | | | | | D’autres traitements seront-ils nécessaires?  Oui  Non Dans **l'affirmative**, précisez ce qui suit : | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | Code int. des dents | | | | | | | | | | | | | Traitements nécessaires et, si possible, le code de l'acte | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Date approximative des traitements (J-M-A) | | | | | | | | | | | | | | | | | | | | |
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| 3. | | | | | Quelles complications pourraient encore survenir et à quel moment? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 4. | | | | | A) Nombre de dents endommagées | | | | | | | | | | | | | | | | | |  | | | | | | | |  | | | | | | | | | | | | | B) Étaient-elles toutes saines et entières?  Oui  Non | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| C) Nombre d’obturations parmi ces dents | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | |  | | | | | | | | | D) Nombre de couronnes parmi ces dents | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | |  | | | | |
| E) Nombre de traitements radiculaires parmi ces dents | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| F) Si les dents ne sont pas toutes saines et entières, précisez. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Signature du dentiste | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | Date | | | | | | | | | | | | J    M    A | | | | | | | |