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|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | PREUVE DU SINISTRE  ASSURANCE CONTRE LES ACCIDENTS DU SPORT  SSQ, Société d’assurance inc. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Bien répondre à toutes les questions, c’est nous aider à mieux vous servir.**  **Directives.** Le blessé doit remplir la « Déclaration de l’assuré », le gérant de l’équipe ou l’administrateur, la « Déclaration du responsable du club », et le médecin traitant, la « Déclaration du médecin traitant », qui se trouve à la page 2.  **Important.** S’il s’agit de soins dentaires, il faut remplir le formulaire « Soins dentaires en cas d’accident du sport ». L’assuré doit tout d’abord envoyer sa demande à l’assureur de tout autre régime d’assurance maladie; si les frais ne sont pas remboursés intégralement, il fait alors parvenir à SSQ, Société d’assurance inc. tous les Relevés de prestations. Conservez une copie des factures de soins médicaux, car nous ne vous retournerons pas l’original. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Note –** Vous pouvez remplir le formulaire au stylo (en majuscules). Il faut cependant que TOUTES les parties signent et datent l'ORIGINAL avant que vous ne l'envoyiez, en y joignant les factures ORIGINALES, 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 de l’assuré | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | **Police n°** | | | | | | | | |  | | | | | | | | | | |
| 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 de l’assuré, 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. Date du premier traitement | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | J    M    A | | | | | | |
| 10. Lieu de l’accident | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 11. L’accident s’est produit pendant une  pratique, une  partie ou un  déplacement autorisés | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Date de départ (de la province de résidence) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | J    M    A | | | | | | | | | | | | | | | | Date de retour (dans la province de résidence) | | | | | | | | | | | | | | | | | | | | | | | | | | J    M    A | | | |
| 12. Description de la blessure | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 13. Description détaillée de l’accident | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 14. Nom et prénom du médecin traitant | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Rue Ville Province Code postal | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 15. Nom, prénom et adresse des autres médecins traitants | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 16. Nom de l’hôpital | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 17. Date de l’hospitalisation | | | | | | | | | | | | | | | | | | J    M    A | | | | | | |
| 18. Autres assurances hospitalisation ou maladie  Oui  Non | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Nom du régime/police n° | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |
| **J’atteste que, à ma connaissance, les renseignements précédents sont exacts et complets.** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Signature du blessé ou, s’il est mineur, d’un des parents ou du tuteur | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Téléphone | | | | | | | | | | | | | | | | | | | | | Date | | | | | | |
| Adresse | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Rue Ville Province Code postal | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Veuillez joindre au présent formulaire dûment rempli l’« Autorisation de collecte, d’utilisation et de divulgation de renseignement personnels ».** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Déclaration du responsable du club | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. Nom de l’équipe | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **2. Police n°** | | | | | | | | | | | |  | | | | | | |
| 3. Nom de la ligue ou de l’association | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 4. Sport | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 5. Date à laquelle le joueur s’est joint à l’équipe | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | J    M    A | | | | | | |
| 6. Jouait-il de façon régulière au moment de l’accident?  Oui  Non | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 7. 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 | | | | | | |
| **Déclaration du médecin traitant** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Page 2 | | | | | | | | | | | | | | | | | Police n° | | | | | | | | | | | | |  | | |
| 1. Nom du patient | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 2. Âge | | | | | | |  |
| 3. Diagnostic de l’affection actuelle | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a) Principal | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b) Secondaire (le cas échéant) | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 4. Date des examens | | | | | | | | | | | | | | | | | J    M    A | | | | | | | | | | | | | | | |  | | | | J    M    A | | | | | | | | | | | | | |  | J    M    A | | | | | | | | | | | | | |  | | J    M    A | | | | |
| 5. À votre connaissance : | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a) Quelle est la date de l’accident ou de l’apparition des symptômes? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | J    M    A | | | | | | | | | | | | | | | | |
| b) Le patient a-t-il déjà présenté une affection de cette nature?  Oui  Non | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Dans l'affirmative, donnez la date et précisez. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 6. Nom de l’hôpital, s’il y a lieu | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Date d’admission | | | | | | | | | | | | | | | J    M    A | | | | | | | | | | | | | | | Heure | | | | | | | | | | |  | | | | |
| Date de sortie | | | | | | | | | | | | | | | J    M    A | | | | | | | | | | | | | | | Heure | | | | | | | | | | |  | | | | |
| 7. Nature de l’opération, s’il y a lieu | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 8. Nom du médecin qui vous a adressé le patient | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 9. Envoi du patient chez un spécialiste  Oui  Non | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Dans l'affirmative, précisez. | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 10. Envoi du patient chez un physiothérapeute  Oui  Non | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Dans l'affirmative, donnez la date. | | | | | | | | | | | | | | | | | | | | J    M    A | | | | | |
| Durée et fréquence du traitement | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Nom du médecin (en majuscules) | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Signature | | | | | | | | | | | |  | | | | | | | | | | | | |
| Adresse | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Rue Ville Province Code postal | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Téléphone | | | | | | | | (     ) | | | | | | | | | | | | | | | | | | | Date | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | J    M    A | | | | | |
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*Il incombe au patient de faire remplir ce formulaire, les frais étant à sa charge.*