## Consent for the Customer Care Centre to Release Personal Information for Spouse or Dependent Child Age 16 and Over



## IMPORTANT: Completing this form is optional.

Complete this form if you, as the spouse or dependent child (16 years or older), covered under a Plan Member's Group Benefits plan, want someone (the advisor and/or plan sponsor of the Plan Member's employer, a family member, etc.) to call the Customer Care Centre (CCC) on your behalf. By completing this form, you agree that the CCC is allowed to provide your personal, claims and/or benefit information to the caller. **Note:** the level of information provided to the caller depends on the selections you make in the form below – please review the form carefully.

**NOTE:** The Plan Member will have access to all information about your claim(s), therefore, authorization for the Plan Member is not required in Section 3 below.

Sun Life Assurance Company of Canada, a member of the Sun Life Financial group of companies, is committed to keeping your information confidential. To learn more about our Privacy Policy and Privacy Code for Canada, please visit www.sunlife.ca/privacy.

Be sure to complete all Plan Member information.	Plan Member's last name	Plan Member's first name	
	Contract number	Plan Member ID	
2 Your information			
Be sure to fully complete this section.	Your last name	Your first name	
	Your relationship to the Plan Member		
	Your daytime telephone number	Your email address	
individual to access your personal information. Be sure to check off the type(s) of personal	☐ Plan Member's Benefits Administrator ☐ Plan Member's Employer's Benefits Consultan	·	
the type(s) of personal information and the purpose(s) of the authorization given to each individual.	Type of personal information (check all that apply):  Group benefit coverage  Health claims This includes drug name or services performed.	For the purposes of (check all that apply):  Providing assistance in the appeal or dispute of a claim	
	Dental claims This includes dental procedures performed.  Other (please specify details):	<ul> <li>□ Receiving ongoing claims information</li> <li>□ Obtaining more information on my behalf</li> <li>□ Other (please specify details):</li> </ul>	
		Please describe any restrictions to the type of information to be disclosed (if any):	

	☐ Other (e.g., a family member Authorized Individual #1:	other than the Plan Member):		
	Last name	First name		Relationship to you
	Authorized Individual #2:			
	Last name	First name		Relationship to you
	Type of personal information (a Group benefit coverage Health claims  • This includes drug name or se Dental claims  • This includes dental procedur  Other (please specify details):	rvices performed.	Providing assist of a claim Receiving ongo Obtaining more Other (please s	s of (check all that apply): cance in the appeal or dispute sing claims information e information on my behalf especify details) e any restrictions to the type of be disclosed (if any):
4 Authorization	and signature  I authorize Sun Life Assurance and for the purposes identified		ose my personal inform	nation to the individual(s)
	I agree that a photocopy or ele is valid until withdrawn by me		ization shall be valid as	the original. This consent
	Your signature X			Date (dd-mm-yyyy)
	Once you have completed the nearest you.	form, it should be returned to	o us by mail or fax to the	e Customer Care Centre
	PO Box 6075 Stn CV Montreal QC H3C 3G5	227 King St S PO Box Waterloo ON N2J 1R Tel: 1-800-361-6212	27	

Fax: 1-866-366-8616

3 Individual(s) you authorize to receive your personal information (if applicable) (continued)

Fax: 1-866-366-8618