Extended Health Care Claim Form

Sun Life Financial

Sun Life Assurance Company of Canada, a member of the Sun Life Financial group of companies, is committed to keeping your information confidential.

1 Member information

You must complete this section.

Contract Number	Member ID			
Last Name	Given Name		Date of Birth (d/m/y)	☐ Male ☐ Female
Street Address			Daytime Telephone Number ( )	
City	Province	Postal Code	Evening Telephone Number ( )	

2 Spouse and Children Covered by this Claim

Complete only if you are attaching expenses for your spouse or children.

Spouse's Full Name ☐ Male ☐ Female	Date of Birth (d/m/y)

Child's Name	Relationship to you		Date of Birth			Complete for overage dependents (refer to benefit information for age limits)	
	Son	Daughter	Day	Month	Year	Disabled	Full-time Student
	☐	☐				☐	☐
	☐	☐				☐	☐
	☐	☐				☐	☐

3 Co-ordination of benefits

Indicate if your spouse and/or children have coverage under any other medical plan or contract.

Are your spouse and/or children covered for any of these expenses under any other medical plan or contract?

No ☐ Yes ☐▶ Spouse's date of birth (d/m/y): _____

If yes,:

- You must submit a claim for your spouse to his/her plan **first**.
- You must submit a claim for your children **first under the plan of the parent** with the earliest birthday (month and day) in the calendar year.

If your spouse's plan is also with us:

Contract Number _____ Member ID: _____

Do you want us to co-ordinate benefits (process both claims)?

No ☐ Yes ☐▶

If yes, Spouse's Signature: X_____ Date (d/m/y) _____

For Plan Administrator Use Only

4 Details of Claim

Attach original receipts
OR
if this claim has been submitted under another plan, attach the original Explanation of Benefits statement from that plan and copies of the receipts.

You must send out-of-country claims to us within 30 days of your return home.

1. Are any expenses the result of an accident? No ☐ Yes ☐▶ If yes, complete the following:

When and where did the accident occur (d/m/y): Work ☐ Home ☐ Other ☐
How did the accident occur?
Are any expenses the result of a condition covered by a workers' compensation program? No ☐ Yes ☐

2. For each category, fill in the totals of the original receipts and/or attach the Explanation of Benefits Statement

Prescription Drugs				$
Out-of-Country Expenses:	Date of departure (d/m/y):	Country:	Currency:	$
Other *(Please specify)*				$
			TOTAL AMOUNT CLAIMED	$

5 Authorization and Signature

You must complete this section.

Fraudulent claims are very costly for all participants in benefit plans. As Administrator of this plan, we may check the accuracy of the information given in support of your claim.

Note for Members: As part of the benefits payment and plan management process, we exchange information about claims with you, including claims for goods or services received by your spouse and dependents. This includes details such as the date of the claim, what the claim was for, and the amount of the claim. **Please ensure that your spouse and/or dependents are aware of, and consent to this process prior to submitting claims.**

I certify that all goods or services being claimed have been received by me, and if applicable, my spouse and/or dependents. I certify that the information in this form is true and complete and does not contain a claim for any expense previously paid for by this or any other plan.

I authorize Sun Life Assurance Company of Canada, its agents and service providers to use and exchange information about me, and if applicable, my spouse and/or dependents, needed for underwriting, administration and adjudicating claims under this Plan with any other person or organization who has relevant information pertaining to this claim including health professionals, institutions, investigative agencies, insurers and reinsurers. I understand that information pertaining to this claim may be reviewed in the event this Plan is audited.

If this claim is being made on behalf of my spouse and/or dependents, I am authorized to disclose information about them, for the purposes of underwriting, administration and adjudicating claims. I confirm that my spouse and/or dependents, if any, also authorize Sun Life Assurance Company of Canada to disclose information about their claims to me, for the purposes of assessing and paying a benefit, if any, and managing my group benefits plan.

I agree that a photocopy or electronic version of this authorization shall be as valid as the original.

Member's signature	Date (d/m/y)
X	

For details specific to your plan, consult your benefit information package or visit our Web site,

www.sunlife.ca

Mail the completed form to the nearest Sun Life Assurance Company of Canada Health Claims office:

EASTERN REGION
Atlantic Canada, Quebec and Eastern Ontario
PO Box 6076 Stn CV
Montreal QC H3C 4S3

CENTRAL REGION
Ontario (except Eastern Ontario)
PO Box 3417 Stn D
Ottawa ON K1P 1G1

WESTERN REGION
Western Canada, N.W.T., Yukon and Nunavut
PO Box 2880 Stn Main
Edmonton AB T5J 4S6

For more information call 1 800 361-6212

Please retain a copy of your claim form and receipts for your records.