

Extended Health Care Claim Form

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	Date of Birth (d/m/y)
Last Name		Given Name	<input type="checkbox"/> Male <input type="checkbox"/> 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		<input type="checkbox"/> Male <input type="checkbox"/> 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
	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>

3 Co-ordination of benefits

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

<p>Are your spouse and/or children covered for any of these expenses under any other medical plan or contract?</p> <p>No <input type="checkbox"/> Yes <input checked="" type="checkbox"/> Spouse's date of birth (d/m/y): _____</p> <p>If yes,:</p> <ul style="list-style-type: none"> 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. <p>If your spouse's plan is also with us:</p> <p>Contract Number _____ Member ID: _____</p> <p>Do you want us to co-ordinate benefits (process both claims)?</p> <p>No <input type="checkbox"/> Yes <input checked="" type="checkbox"/></p> <p>If yes, Spouse's Signature: <u>X</u> Date (d/m/y) _____</p>	<p>For Plan Administrator Use Only</p>
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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 <input type="checkbox"/>	Home <input type="checkbox"/>	Other <input type="checkbox"/>
How did the accident occur?			
Are any expenses the result of a condition covered by a workers' compensation program? No <input type="checkbox"/> Yes <input type="checkbox"/>			

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.

I certify that all goods or services being claimed have been received by me/my dependents. 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 assessing and paying a benefit, if any.

I certify that the information in this form is true and complete and does not contain a claim for any expenses 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 needed for underwriting, administration and adjudicating claims under this Plan with any person or organization who has relevant information pertaining to this claim including health professionals, institutions, investigative agencies, insurers and reinsurers. I understand that information about me pertaining to this claim may be reviewed in the event that this Plan is audited.

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

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

PO Box 6076 Stn CV
Montreal QC H3C 4S3
1 800 361-2128

CENTRAL REGION
Ontario

PO Box 3417 Stn D
Ottawa ON K1P 1G1
1 800 361-6212

WESTERN REGION
**Western Canada, N.W.T.
and Yukon**

PO Box 2880 Stn Main
Edmonton AB T5J 4S6
1 800 661-7334