

# 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<br><b>71202</b> | Member ID  |                                 |  |
| Last Name                       | Given Name | Date of Birth (d/m/y)           | <input type="checkbox"/> Male<br><input type="checkbox"/> Female |
| Street Address                  |            | Daytime Telephone Number<br>( ) |  |
| City                            | Province   | Postal Code                     | Evening Telephone Number<br>( )                                  |

## 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 coverage 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"> <li>You must submit a claim for your spouse to his/her plan first.</li> <li>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.</li> </ul> <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> |
|---|--|

#### 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)   | \$ |
| <b>TOTAL AMOUNT CLAIMED</b>  | \$ |

#### 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<br>X | Date (d/m/y) |
|-------------------------|--------------|

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

[www.sunlife.ca](http://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 4023 Stn A  
Toronto ON M5W 2P7

**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.**