CAE

Sun Life Financial

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		Date of Birth
25289	0 [ ] division; 0 0 0 [ ] [ ] [ ] [ ] [ ] employee No. (salaried=2 unionized=3)	Day / Month / Year
Last Name	Given Name	☐ Male ☐ Female
Street Address		Daytime Tel. No. ( )
City	Province / Postal Code	Evening Tel. No. ( )

2 Spouse and Children Covered by this Claim

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

Spouse's Full Name		Date of Birth
	☐ Male ☐ Female	Day / Month / Year

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: / / (Day Month Year)

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: _____ Date: / / (Day Month Year)

For Plan Administrator Use Only

continued on reverse side

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.

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

When and where did the accident occur? Day / Month / Year	Work ☐ Home ☐ Other ☐
How did the accident occur?	
Are any expenses the result of a condition covered by a workers' compensation program ?	No ☐ Yes ☐

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

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: Day / Month / Year — 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 Signature	Date Day / Month / Year

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 4023 Stn A
Toronto ON M5W 2P7

WESTERN REGION

Western Canada, N.W.T. and Yukon

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.