Health Care Claim Form

Sun Life Financial

All claims must be submitted to Sun Life Assurance Company of Canada at the address below no more than SIX MONTHS following the date on which the expenses are incurred.

Claimants must provide a valid Canadian address for reimbursement. Claimant reimbursement cheques will not be issued to a non-Canadian address.

Please PRINT clearly.

Clear

1 Member information

Member identification number	Policy number	Plan sponsor
	017857	College Health Insurance Plan (C-HIP)

Last name	Middle name	First name

Date of birth (dd-mm-yyyy)	Sex	Telephone number	Email address
– –	☐ Male ☐ Female	– –	

Canadian address (street number and name)	Apartment or suite

City	Province	Postal code

2 Complete this section if you or your spouse are covered under another plan

Send your claims to your own plan first. When you receive your claim statement, send a copy plus copies of your receipts to your spouse's plan to claim any unpaid amount.

Send your spouse's claims to their plan first, then send a copy of their claim statement and receipts to your plan.

Send your children's claims first to the plan of the parent whose birthday falls earlier in the year.

Is your spouse a member of another benefit plan? No Yes If yes, please provide details below.

Spouse's last name	First name	Date of birth (dd-mm-yyyy)	Type of coverage
		– –	Single Family

Are you claiming any expenses that are **NOT** covered under your spouse's plan? No Yes If yes, please specify:

If your spouse's benefit plan is with Sun Life Financial, do you want us to process the claim through both benefit plans?	Contract number	Member ID number
No Yes		

Spouse's signature	Date (dd-mm-yyyy)
X	– –

Are you also a member of another benefit plan? No Yes If yes, please provide details below.

Type of coverage	Are you claiming any expenses that are **NOT** covered under your other plan? No Yes If yes, please specify:
Single Family	

If your other benefit plan is with Sun Life Financial, do you want us to process the claim through both benefit plans?	Contract number	Member ID number
No Yes		

Respecting your privacy

Your privacy is important to us. We may leverage our strengths in our worldwide operations and in our negotiated relationships with third-party providers to help us service some of our customers. In some instances our employees, service providers, agents, reinsurers and any of their service providers, may be located in jurisdictions outside Canada, and your personal information may be subject to the laws of those foreign jurisdictions.

To find out about our Privacy Policy, visit our website at *www.sunlife.ca*, or to obtain information about our privacy practices, send a written request by email to *privacyofficer@sunlife.com*, or by mail to Privacy Officer, Sun Life Financial, 225 King St. West, Toronto, ON M5V 3C5.

Questions? Please visit **www.sunlife.ca** or call our toll-free number 1-888-206-9004 Monday - Friday, 8 a.m. - 8 p.m. ET

For SLF use:
HCF

3 Information about your claim

List the names of all persons for whom you are claiming expenses. Add up all the receipts and insert the total amount claimed. Ensure each receipt clearly indicates the type of expense being claimed.

Attach ORIGINAL receipts indicating that you have paid the provider in full (photocopied bills/receipts are not acceptable).

Person for whom you are making the claim		Date of birth (dd-mm-yyyy)	Relationship to you	Full-time student	Disabled	Amount claimed
Last name	First name			☐ Yes ☐ No	☐ Yes ☐ No	$
Last name	First name			☐ Yes ☐ No	☐ Yes ☐ No	$
Last name	First name			☐ Yes ☐ No	☐ Yes ☐ No	$
Last name	First name			☐ Yes ☐ No	☐ Yes ☐ No	$
						Total claimed $

Are you attaching receipts for out-of-Canada expenses? ☐ No ☐ Yes

If yes, tell us the date of departure from claimant's home province. Ensure the currency and amount are clearly marked on each receipt. We'll assess your claim and convert the eligible expenses to Canadian dollars.

Date (dd-mm-yyyy)	Out-of-Canada expenses claimed
	$

Are any of the expenses you're claiming the result of a work injury? ☐ No ☐ Yes

If yes, did you submit your claim to the workers' compensation plan in your province, if applicable? ☐ No ☐ Yes

Are any of the expenses you're claiming the result of a motor vehicle accident? ☐ No ☐ Yes

If yes, did you submit your claim to the automobile insurance plan in your province, if applicable? ☐ No ☐ Yes

4 Authorization and signature

I certify that all goods and services being claimed have been received by me and/or my spouse or dependents, if applicable. 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.

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 ("Sun Life") 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 authorize Sun Life and its reinsurers to collect, use and disclose information about me, and if applicable, my spouse and/or dependents needed for underwriting, administration and adjudicating claims under this Plan to any other organization who has relevant information pertaining to this claim including health professionals, institutions, investigative agencies and insurers. I also understand that information pertaining to this claim may be reviewed in the event this Plan is audited.

In the event there is suspicion and/or evidence of fraud and/or Plan abuse concerning this claim, I acknowledge and agree that Sun Life may investigate and that information about me, my spouse and/or dependents pertaining to this claim may be used and disclosed to any relevant organization including regulatory bodies, government organizations, medical suppliers and other insurers, and where applicable my Plan Sponsor, for the purpose of investigation and prevention of fraud and/or Plan abuse.

If there is an overpayment, I authorize the recovery of the full amount of the overpayment from any amount payable to me under my benefit plan(s), and the collection, use and disclosure of information about this claim to other persons or organizations, including credit agencies and, where applicable, my Plan Sponsor for that purpose.

I agree that a photocopy or electronic version of this authorization shall be as valid as the original, and may remain in effect for the continued administration of this Plan.

Any reference to Sun Life Assurance Company of Canada or the Plan Sponsor includes their respective agents and service providers.

If the (group) life insured is a minor (as defined in the applicable provincial jurisdiction), the person responsible for the minor should sign the claim form as claimant.

If this claim is being made in respect of a minor, the claimant confirms that he or she has legal responsibility for the minor.

Important

Check one of the following boxes:

☐ Payment is to be made to the member.
☐ Payment is to be made directly to the provider.

Claimant's signature	Date (dd-mm-yyyy)
X	

Guardian's last name	First name

Guardian's signature	Date (dd-mm-yyyy)
X	

5 Provider information

Section 5 and 6 is to only be completed by the provider when reimbursement is to be made directly to provider.

Provider's name	Physician's name	
Address of provider (street number and name)		Apartment or suite
City	Province	Postal code
SLF Provider ID number	Telephone number	

6 Statement of services (Physicians and hospitals must provide the diagnosis.)

Service date (dd-mm-yyyy)	Description of service	OHIP procedure code (plus time units, if applicable)	Charge	Diagnosis

I declare that the above is a correct statement of the services rendered.

Provider's signature	Date (dd-mm-yyyy)
X	

DIRECT ALL CLAIMS AND INQUIRIES TO:

Sun Life Assurance Company of Canada
Claims Department
PO Box 2015 Stn Waterloo
Waterloo ON N2J 0B1

Toll free: 1-888-206-9004

You must provide your member ID when contacting us by telephone.