Health Care Claim Form

All claims must be submitted to Sun Life Assurance Company of Canada at the address below no more than 180 days 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.

Sun Life Assurance Company of Canada is the insurer, and is a member of the Sun Life Financial group of companies.

1 Member information

Member identification number	Policy number	Plan sponsor	
	17857	**College Health Insurance Plan (C-HIP)**	
Last name	Middle name	First name	
Date of birth (dd-mm-yyyy)	Gender ☐ Male ☐ Female	Telephone number	Email address
Canadian address (street number and name)			Apartment or suite
City	Province		Postal code

2 Claim information

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

Last name	First name	**Date of birth (dd-mm-yyyy)**	**Amount claimed**
Last name	First name	– –	$
Last name	First name	– –	$
Last name	First name	– –	$
			Total claimed $

3 Member authorization and signature (this section is to be completed when reimbursement is made directly to the claimant)

Authorization

I authorize the healthcare provider/clinic named above to submit claims on my behalf and my dependents (if applicable) to Sun Life Assurance Company of Canada (Sun Life).

I authorize Sun Life, its agents and services providers and as applicable the plan administrators to collect, use and exchange information needed for underwriting, administration, adjudicating claims and claims management under this insurance coverage. This information can be shared with any person or organization who has relevant information about me including health professionals, government agencies, provincial health care plan, institutions, investigative agencies insurers, re-insurers and, as applicable, the plan sponsor and plan administrator.

If there is suspicion of fraud and/or abuse related to my claim, I understand and agree that Sun Life, its agents and service providers may exchange information about my claim for the purpose of investigation and prevention of fraud and/or abuse with any relevant organization, including as applicable the plan sponsor and plan administrator, law enforcement bodies, regulatory bodies, government organizations and other insurers.

If there is an overpayment, I authorize the recovery of the full amount of the overpayment from any amount payable to me. If I am submitting claims for my spouse and/or dependents, I confirm that I am authorized by them to disclose personal information about them for the purposes described above to Sun Life, its agents and services providers and any person or organization who has relevant information about them including health professionals, government agencies, provincial health care plan, institutions, investigative agencies insurers, re-insurers and, as applicable, the plan sponsor and plan administrator.

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

For SLF use:
HCF

3 Authorization and signature (continued)

Important

Check one of the following boxes:

☐ Payment is to be made to the member. **(Member signature is required below). Enclose all receipts (proof of payments) with your submission and keep a copy for your records.**

☐ Payment is to be made directly to the provider. **(Member signature NOT required)**

Member's signature X		Date (dd-mm-yyyy) – –
Guardian's last name (required if member is 15 years old or younger)	First name	
Guardian's signature (required if member is 15 years old or younger) X		Date (dd-mm-yyyy) – –

Respecting your privacy

Respecting your privacy is a priority for the Sun Life Financial group of companies. We keep in confidence personal information about you and the products and services you have with us to provide you with investment, retirement and insurance products and services to help you meet your lifetime financial objectives. To meet these objectives, we collect, use and disclose your personal information for purposes that include: underwriting; administration; claims adjudication; protecting against fraud, errors or misrepresentations; meeting legal, regulatory or contractual requirements; and we may tell you about other related products and services that we believe meet your changing needs. The only people who have access to your personal information are our employees, distribution partners such as advisors, and third-party service providers, along with our reinsurers. We will also provide access to anyone else you authorize. Sometimes, unless we are otherwise prohibited, these people may be in countries outside Canada, so your personal information may be subject to the laws of those countries. You can ask for the information in our files about you and, if necessary, ask us in writing to correct it. To find out more about our privacy practices, visit *www.sunlife.ca/privacy*.

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

4 Provider information

Sections 4 and 5 need to be fully completed in the absence of an invoice with the same information.

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

5 Statement of services

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

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

Provider's signature (A signature is required only in the absence of an invoice) X	Date (dd-mm-yyyy) – –

Please mail completed form and supporting documents to:

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

Members may direct their questions to the toll free phone number of 1-888-206-9004.

(You must provide your contract number (017857) and your member id. Both of these can be found on your C-HIP coverage card.)