Extended Health Care claim form for Personal Health Insurance

Sun Life Assurance Company of Canada, a member of the Sun Life Financial group of companies, is committed to keeping your information confidential.

1 Policyowner information

You must complete this section.

Policy Number 37000	ID N°	Date of Birth (d/m/y)	
Last Name	Given Name ☐ Male ☐ 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 ☐ Male ☐ Female	Date of Birth (d/m/y)

Child's Name	Relationship to you		Date of Birth			Complete for overage dependants (refer to benefit information for age limits)	
	Son	Daughter	Day	Month	Year	Disabled	Full-time Student
	☐	☐				☐	☐
	☐	☐				☐	☐
	☐	☐				☐	☐

3 Details of Claim

Attach original 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 ☐ Home ☐ Other ☐
How did the accident occur?
Are any expenses the result of a condition covered by a workers' compensation program? No ☐ Yes ☐

2. For each category, fill in the totals of the original receipts

Prescription Drugs	$
Out-of-Country Expenses: Date of departure (d/m/y): Country: Currency:	$
Other *(Please specify)*	$
TOTAL AMOUNT CLAIMED	$

4 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 dependants. If this claim is being made on behalf of my spouse and/or dependants, 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 advisors 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.

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

Mailing instructions – *keep a copy of your claim form and receipts for your records*

For details specific to your plan, consult your Policy or call 1 877 SUN-LIFE (1 877 786-5433)

Mail the completed form to:

Sun Life Assurance Company of Canada
Health and Dental Claims
PO Box 3417 Stn D
Ottawa ON K1P 1G1