CLAIM FORM

Sections 1 to 3 must be completed by the member; Sections 4 and 5 must be completed by the provider. Attach ORIGINAL bills from the provider or receipts indicating that you have paid the provider in full (photocopied bills/receipts are not acceptable). Remember to indicate your member identification number, and sign and date the AUTHORIZATION section.

All claims must be submitted to Sun Life Assurance Company of Canada, a member of the Sun Life Financial group of companies (the insurer), no more than SIX MONTHS following the date on which the expenses are incurred.

SECTION 1 - MEMBER INFORMATION

Policy number 50150 Member identification number |__|__|__|-|__|__|__|-|__|__|__|-|__|__|__|

University name Last name

First and middle names

Canadian address No: Street Apt.#

City Province Postal code

Date of birth |__|__| |__|__| |__|__| Year Month Day Sex ❑ M ❑ F Tel.# (_____) |__|__|__|-|__|__|__|__|

SECTION 2 - PATIENT INFORMATION

Last name

First name Date of birth |__|__| |__|__| |__|__| Year Month Day

Relationship to member ❑ Member ❑ Spouse ❑ Son ❑ Daughter

SECTION 3 - AUTHORIZATION

I certify that the statements in this form are true and complete. I understand that the insurer may investigate this claim.

I authorize the insurer, its agents and service providers to use and exchange information needed for underwriting, administration and adjudicating claims, and with the UHIP® plan administrator, for the purposes of claims management and intervention as appropriate on my behalf, under this insurance coverage with any person or organization who has relevant information about me including health professionals, government agencies, provincial health care plan, institutions, investigative agencies, insurers, and reinsurers.

I understand that for audits and administrative reporting, the plan sponsor or administrator of this insurance coverage may have access to statistical and financial information without any personal identifiers. I agree that a photocopy or electronic version of this authorization is as valid as the original and shall continue to have effect throughout the duration of my claim.

I authorize the insurer and its medical consultants to exchange information about me with my health professional(s) for the purpose of claims management and intervention as appropriate on my behalf.

Insurance fraud is a crime. According to the Criminal Code of Canada, anyone who defrauds an insurance company can be found guilty of a criminal offence. Submission of false information in connection with this claim, therefore, may constitute a crime. In the event of insurance fraud, the insurer shall pursue all appropriate legal action, including criminal prosecution.

IMPORTANT: Check one of the following boxes:
❑ **Payment is to be made to the member.**
❑ **Payment is to be made directly to the provider.**

Member's signature **Date**

Do you or your dependents have coverage for these expenses under any other plan? ❑ Yes ❑ No

If yes, insurance company name _____ Policy # _____ Country _____

SECTION 4 - PROVIDER INFORMATION

Provider's name Specialty

Address City Prov. Postal code

SLF Provider I.D.# |__|__|__|__|__|__|__|

Tel.# (_____) |__|__|__|-|__|__|__|__|

SECTION 5 - STATEMENT OF SERVICES (Physicians and hospitals must provide the diagnosis.)

Service date	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**

DIRECT ALL CLAIMS AND INQUIRIES TO: Sun Life Assurance Company of Canada
Claims Department
PO Box 9845 STN T
Ottawa ON K1G 6V4

Toll free: 1-866-500-UHIP (8447)
E-mail: askus@sunlife.com

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