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.
- Use this form for **all** medical expenses and services. For dental expenses, please use the *Dental Claim Form*.
- Please print clearly and be sure all sections are complete to avoid delays in processing your claim.
- Attach the **original** receipt for each expense claimed and keep photocopies for your records.
- Sign on page 2 and mail your claim to the address at the bottom of page 2. Some plans allow claims to be submitted online at **www.sunlife.ca**

Questions? Please visit **www.sunlife.ca**
or call **1- 800-361-6212** Monday – Friday, 8 a.m.– 8 p.m. ET

1 Information about you

Be sure to fully complete this section.

Contract number	Member ID number	Your plan sponsor/employer	
50131		**OMA Priority Insurance Program**	
Your last name	First name	☐ Male ☐ Female	Date of birth (dd/mm/yy)
Your address (street number and name, apartment or suite)		City	
Province	Postal code	You'd prefer correspondence in ☐ English ☐ French	Daytime phone number ( )

2 Are you or your spouse covered under another plan?

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/yy)
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? ☐ No ☐ Yes ►	Contract number	Member ID number

Spouse's signature	Date (dd/mm/yy)
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?	What is your employment status under your other benefits plan?
☐ Single ☐ Family	☐ No ☐ Yes If yes, please specify:	☐ Full-time ☐ Part-time ☐ Retired
If your other benefit plan is with Sun Life Financial, do you want us to process the claim through both benefit plans? ☐ No ☐ Yes ►	Contract number	Member ID number

3 Information about your claim

List the names of all persons for whom you're claiming expenses. Add up all the receipts and insert the total amount claimed.

Ensure each receipt clearly indicates the type of expense being claimed.

Person for whom you are making the claim	Date of birth (dd/mm/yy)	Relationship to you	Full-time student	Disabled	Amount claimed
Claimant (last name, first name)	| |		☐ Yes ☐ No	☐ Yes ☐ No	$
Claimant (last name, first name)	| |		☐ Yes ☐ No	☐ Yes ☐ No	$
Claimant (last name, first name)	| |		☐ Yes ☐ No	☐ Yes ☐ No	$
Claimant (last name, first name)	| |		☐ Yes ☐ No	☐ Yes ☐ No	$
Claimant (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/yy)

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

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.

Note for Members: As part of the benefits payment and plan management process, we exchange information about claims with you, including claims for goods or services received by your spouse and dependents. This includes details such as the date of the claim, what the claim was for, and the amount of the claim. **Please ensure that your spouse and/or dependents are aware of, and consent to this process prior to submitting claims.**

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

I authorize Sun Life Assurance Company of Canada, its agents and service providers to use and exchange information about me, and if applicable, my spouse and/or dependents, needed for underwriting, administration and adjudicating claims under this Plan with any other person or organization who has relevant information pertaining to this claim including health professionals, institutions, investigative agencies, insurers and reinsurers. I understand that information pertaining to this claim may be reviewed in the event this Plan is audited.

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 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 agree that a photocopy or electronic version of this authorization shall be as valid as the original.

Member's signature	Date (dd/mm/yy)
X	| |

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

Mail your completed form to the claims office nearest you.

Sun Life Assurance Company of Canada

PO Box 4023 Stn A
Toronto ON M5W 2P7