

Extended Health Care Claim Form



For SLF use:

HCF

- 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.

Questions? Please visit www.studentcare.ca

Important:

• 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.

All claims must be received by Sun Life Assurance Company of Canada no later than 90 days after the end of the policy year in which the claims were incurred or 90 days after the end of your coverage, whichever is sooner. For more information, refer to your booklet or get in touch with Studentcare. Attach a written statement from the referring doctor if you are claiming for certain medical services or expenses such as medical equipment, nursing services. The written statement should confirm why the services were medically necessary and how long the services were needed. If the expenses were the result of a dental accident, we require X-rays taken after the accident and before any treatment.

I Information a	abou	t you	u — De	e sure	το τυ	шу сс	implete this se	ection								
Contract number	Stude	nt ID n	umber				p name						Pr	eferred lar	iguage of c	orrespondence
141012						Qu	een's SGP	S Health	Plan					English	☐ French	
Your last name	•				First r	name				☐ Male		Date of birt	th (yyy	y-mm-dd)	Daytime	phone number
Your address (street number	er and na	ame)					Apartment or suite	e City					Provir	ice	Postal co	ode
2 Complete thi	is sec	tion	if yo	ou or	your	spo	use are cove	red unde	r anotl	ner pla	n					
Send your claims to y				irst. W	hen y	ou re	ceive your cla	im stateme	ent, sen	d a copy	y plu	ıs copies	of yo	ur rece	ipts to y	our spouse's
Send your spouse's c	laims	to th	neir pl	an firs	t, the	n sen	d a copy of th	eir claim st	atemen	it and re	eceip	ots to you	ır pla	n.		
Send your children's	claims	s first	: to th	ne plar	n of th	ne pa	rent whose bir	thday falls	earlier i	in the y	ear.					
Is your spouse a mem	ber of	anot	:her b	enefit	plan?		□ No □ Ye	es If yes,	please p	orovide (detai	ls below.				
Spouse's last name Firs				First	name	Date				Date of birt	Date of birth (yyyy-mm-dd)			coverage e 🗌 Family		
Are you claiming any expen	nses that	are N (OT cove	ered und	ler your	spouse	e's plan? No	☐ Yes I	f yes, plea	se 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 Certificate identification number																
If your spouse's benefit plan	n is with	Sun Li	fe Finan	ncial, do	you war	nt us to	process the claim t	through both be			Con	tract number		Cer	tificate idei	ntification number
Spouse's signature															Date sign	ned (yyyy-mm-dd)
Are you also a member	er of a	nothe	er ber	nefit p	lan?		No □ Yes	If yes, p	lease pr	ovide de	tails	below.			•	
Type of coverage	Are	e you c	laiming	any exp	enses th	nat are	NOT covered under	your other pla	ın? 🗆	No 🗆	Yes	If yes, ple	ease sp	ecify:		
What is your employment status under your other benefits plan? ☐ Full-time ☐ Part-time ☐ Retired				its	If your other benefit plan is with Sun Life Financial, do you want us to process the claim through both benefit plans?					tract number	Certificate identification number					
3 Information a List the names of all pe indicates the type of e	ersons	for w	/hom y	you are	e claim	ning ex			eipts and	d insert t	he to			imed. En	sure eac	h receipt clearly
Person for whom you are m	aking th	e clain	n					Date of birth (yyyy-mm-dd)	ı	Relations	hip to		l-time dent	Disabled	Amount c	:laimed
Last name Fi			First	First name								Yes No	☐ Yes ☐ No	\$		
Last name			First	First name							-	Yes No	☐ Yes ☐ No	\$		
Last name			First	name								Yes No	☐ Yes ☐ No	\$		
Last name			First	First name								Yes No	☐ Yes ☐ No	\$		
				-						1					Total cla	imed

3 Information about your claim (continued)	
Are any of the expenses you're claiming the result of a work injury? If yes, did you submit your claim to the workers' compensation plan in your province, if applicable?	☐ No ☐ Yes ☐ No ☐ Yes
Are any of the expenses you're claiming the result of a motor vehicle accident? If yes, did you submit your claim to the automobile insurance plan in your province, if applicable?	☐ No ☐ Yes ☐ No ☐ Yes
A Authorization and demandation	

4 Authorization and signature – you must complete this section

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 authorize Sun Life Assurance Company of Canada to disclose the information pertaining to this claim to Studentcare for benefits administration. 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.

Signature of Insured Student (Mandatory)	Date (yyyy-mm-dd)
X	

5 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 1-800-361-6212 Monday - Friday, 8 a.m. - 8 p.m. ET

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

Important: All claims must be received by Sun Life Assurance Company of Canada no later than 90 days after the end of the policy year in which the claims were incurred or 90 days after the end of your coverage, whichever is sooner. For more information, refer to your booklet or get in touch with Studentcare. If you are under a treatment program which will involve a series of treatments for an extended period you should file a claim periodically and indicate on the claim form that it is part of an on-going treatment plan.

For details specific to your Plan, visit www.studentcare.ca

Mail your completed form to: Sun Life Assurance Company of Canada PO Box 2010 Stn Waterloo Waterloo ON N2J 0A6

Please retain a copy of your claim form and receipts for your records.