Extended Health Care Claim Form

- Use this form for **all** medical expenses and services. For dental expenses, please use the *Dental Claim Form*.
- Please read all instructions before completing the 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. We will not return original receipts since you will receive a Claim Statement for income tax purposes.
- Sign on page 2 and mail your claim to the address at the bottom of page 2.

Questions? Please visit www.ihaveaplan.ca

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.net/works.

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.

1 Information about you – *be sure to fully complete this section*

Contract number	Student ID number	Group name	Preferred language of correspondence
50197		Royal Roads University Student Health Plan	☐ English ☐ French

Your last name	First name		Date of birth (yyyy-mm-dd)	Daytime phone number
		☐ Male ☐ Female		

Your address (street number and name)	Apartment or suite	City	Province	Postal code

2 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 covered by another Extended Health Plan? ☐ No ☐ Yes If yes, please provide details below.

Spouse's last name	First name	Date of birth (yyyy-mm-dd)	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 health plan is with Sun Life Financial, do you want us to process the claim through both health plans? ☐ No ☐ Yes	Contract number	Certificate identification number
Spouse's signature X		Date (yyyy-mm-dd)

Are you also covered by another Extended Health Plan? ☐ No ☐ Yes If yes, please provide details below.

Type of coverage ☐ Single ☐ Family	Are you claiming any expenses that are **NOT** covered under your other plan? ☐ No ☐ Yes If yes, please specify:		
What is your employment status under your other benefits plan? ☐ Full-time ☐ Part-time	If your other health plan is with Sun Life Financial, do you want us to process the claim through both health plans? ☐ No ☐ Yes	Contract number	Certificate identification number

3 Information about your claim

List the names of all persons for whom you are claiming expenses. Add up all the receipts and insert the total amount claimed. Your receipts should include the name of the patient, the nature of the treatment or medical product, the name of the prescribing physician, the date and the amount charged.

Person for whom you are making the claim		Date of birth (yyyy-mm-dd)	Relationship to you	Full-time student	Disabled	Amount claimed
Last name	First name			☐ Yes ☐ No	☐ Yes ☐ No	$
Last name	First name			☐ Yes ☐ No	☐ Yes ☐ No	$
Last name	First name			☐ Yes ☐ No	☐ Yes ☐ No	$
Last name	First name			☐ Yes ☐ No	☐ Yes ☐ No	$
					Total claimed	$

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3 Information about your claim (continued)

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*

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.net/works 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	

Respecting your privacy

Your privacy is important to us. We may leverage our strengths in our worldwide operations and in our negotiated relationships with third-party providers to help us service some of our customers. In some instances our employees, service providers, agents, reinsurers and any of their service providers, may be located in jurisdictions outside Canada, and your personal information may be subject to the laws of those foreign jurisdictions.

To find out about our Privacy Policy, visit our website at *www.sunlife.ca*, or to obtain information about our privacy practices, send a written request by e-mail to *privacyofficer@sunlife.com*, or by mail to Privacy Officer, Sun Life Financial, 225 King St. West, Toronto, ON M5V 3C5.

Questions? Please visit **www.sunlife.ca** or call toll-free 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*

Mail your completed form to:.

Sun Life Assurance Company of Canada
Group Claims Department
PO Box 2010 Stn Waterloo
Waterloo ON N2J 0A6

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