Claim Form

Sun Life Financial

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.

Please PRINT clearly.

Policy numbers

Sun Life Assurance Company of Canada – 50150 **American Home Assurance Company – SRG9114277**

Your privacy is important to us. To view Sun Life Financial's privacy policy please refer to www.sunlife.ca or to the UHIP® booklet "University Heath Insurance Plan (UHIP®) your basic health care solution" which can be found at www.uhip.ca.

All claims must be submitted to Sun Life Assurance Company of Canada at the address below no more than TWELVE MONTHS following the date on which the expenses are incurred.

1 Member information

University name		Member identification number	
Last name		First and middle names	
Date of birth (d/m/y)	Sex ☐ Male ☐ Female	Telephone # ( )	Email address
Canadian address (street number and name, apartment or suite)			
City	Province	Postal code	

2 Patient information

Last name	First name	
Date of birth (d/m/y)	Relationship to member	☐ Member ☐ Son ☐ Spouse ☐ Daughter

3 Authorization and signature

Personal Information Notice

I understand that the information provided by me on this claim form and otherwise in respect of my claim, is required by Sun Life Assurance Company of Canada and American Home Assurance Company, their reinsurers and authorized administrators (the "Insurers") to assess my entitlement to benefits as well as to administer and underwrite claims, including but not limited to determining if coverage is in effect, investigating the applicability of exclusions and coordinating coverage with each other and other insurers. For these purposes, the Insurers will also consult their existing insurance files about me, collect additional information about and from me, and where required, collect information from and exchange information with, third parties.

Certification

The statements I provide in completing this claim form and otherwise in respect of my claims are true and complete to the best of my knowledge and belief. In the event of a false or misleading statement in the making of this claim, coverage can be cancelled, payment of benefits denied and past claims payments recovered. I agree to refund to the Insurers, the amount of any payments made in the event that such amounts should not have been paid in respect of my claim.

Authorization

I authorize, for a period of not less than twelve and not more than twenty-four months from the date hereof, any physician, practitioner, health care provider, hospital, health care institution, medical organization, clinic and any other medical or medically related facility, any insurance company or reinsurance company, workers compensation board or similar plan or organization, UHIP plan administrator, federal, territorial or provincial government department, or any other corporation or organization, institution or association (including obtaining information from the group policyholder or my employer) to release and exchange with Sun Life Assurance Company of Canada and American Home Assurance Company, their agents, service providers or representatives, all personal health information, benefit payment, employment or financial information about me or any other information or records about me in its possession that is requested while administering my claim.

3 Authorization and signature (continued)

I understand that for audits and administrative reporting, the plan sponsor or UHIP plan administrator of this coverage may have access to statistical and financial information without any personal identifiers. I agree that a reproduction of this authorization shall be as valid as the original.

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 (d/m/y)
X	

Do you or your dependents have coverage for these expenses under any other plan? ☐ Yes ☐ No
If yes,

Insurance company name	Policy #	Country

4 Provider information

Provider's name	Specialty	
Address (street number and name, apartment or suite)		
City	Province	Postal Code
SLF Provider ID #	Telephone #	

5 Statement of services (Physicians and hospitals must provide the diagnosis.)

Service date (d/m/y)	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 (d/m/y)
X	

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

*Sun Life Assurance Company of Canada insures eligible claims up to $100,000 per insured person per year and acts as an administrator on behalf of American Home Assurance Company for claims exceeding $100,000 per year (add). In all cases, claims submissions or inquiries should be directed to Sun Life.