

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													Sex	<input type="checkbox"/> M	Tel.# (_____)						-				
	Year			Month			Day				<input type="checkbox"/> F														

SECTION 2 - PATIENT INFORMATION

Last name																					
First name													Date of birth								
													Year				Month			Day	
Relationship to member	<input type="checkbox"/> Member			<input type="checkbox"/> Spouse			<input type="checkbox"/> Son			<input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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						
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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

