Sun Life

# Extended Health Care & Health Spending Account Claim Form

## IMPORTANT:

- Please read the instructions as incomplete forms will delay processing.
- All medical information received under this plan is confidential. As part of audits or administrative reports, your plan sponsor may have access to statistical and financial information, but your name will not appear on any medical information released to your plan sponsor.
- Fraudulent claims are very costly for all participants in benefit plans. As administrator of this plan, Sun Life may check the accuracy of the information given in support of your claim.
- Attach a written statement from the referring doctor if you are claiming for medical services or expenses such as medical equipment, nursing services, physiotherapy, speech therapy and massage therapy.
- You must send out-of-country claims to Sun Life within 30 days of your return home.
- For details specific to your plan, consult your benefit information package.

## Member Information

**You must complete this section.**

| Contract Number | Member ID | Date of Birth Day Month Year |
|---|---|---|
| | | / / |
| **Last Name** | **Given Name** | **Sex** ☐ Male ☐ Female |
| **Street Address** | | **Daytime Tel. No.** ( ) |
| **City** | **Province** / **Postal Code** | **Evening Tel. No.** ( ) |

## Spouse and Children Covered by this Claim

**Complete only if you are attaching expenses for spouse or children.**

| Spouse's Full Name | Sex ☐ Male ☐ Female | Date of Birth Day Month Year |
|---|---|---|
| | | / / |

| Child's Name | Relationship to you | | Date of Birth | | | Complete for overage dependents (refer to benefit information for age limits) | |
|---|---|---|---|---|---|---|---|
| | Son | Daughter | Day | Month | Year | Disabled | Full-time Student |
| | ☐ | ☐ | | | | ☐ | ☐ |
| | ☐ | ☐ | | | | ☐ | ☐ |
| | ☐ | ☐ | | | | ☐ | ☐ |

## Coordination of Benefits

**Complete only if your spouse and/or children have coverage under any other medical plan or contract.**

Are your spouse and/or children covered for any of these expenses under any other medical plan or contract?

No ☐ Yes ☐ ▶ Spouse's date of birth: / / (Day Month Year)

**If yes:**

- You must submit a claim for your spouse to his/her plan **first.**
- You must submit a claim for your children **first** under the plan of the parent with the earliest birthday (month and day) in the calendar year.

**If your spouse's plan is also with Sun Life:**

Contract Number: _____ Member ID: _____

Do you want Sun Life to co-ordinate benefits (process both claims)?

No ☐ Yes ☐ ▶

If yes, Spouse's Signature: _____ Date: / / (Day Month Year)

**For Plan Administrator Use Only**



*CONTINUED ON REVERSE SIDE*

## Details of Claim

**Attach original receipts OR if this claim has been submitted under another plan, attach the original Explanation of Benefits statement from that plan and copies of the receipts.**

1. Are any expenses the result of an accident? No ☐ Yes ☐ If yes, complete the following:

| | |
|---|---|
| When and where did the accident occur? Day / Month / Year | Work ☐ Home ☐ Other ☐ |
| How did the accident occur? | |
| Are any expenses the result of a condition covered by Workers' Compensation/Workplace Safety and Insurance Board? No ☐ Yes ☐ | |

2. For each category, fill in the totals of the original receipts and/or attach the Explanation of Benefits Statement.

| | |
|---|---|
| Prescription Drugs * (see no. 3 below) | $ |
| Out-of-Country Expenses: What was the date of departure? Day / Month / Year | $ |
| Other *(Please specify)* | $ |
| **TOTAL AMOUNT CLAIMED** | **$** |

**Complete only if you have an Assure Drug Card AND You are submitting prescription receipts.**

3. **Do you have an Assure Drug Card?**

No ☐ Yes ☐ ☐☐ ☐☐☐☐☐☐ ☐☐☐☐☐☐☐☐☐☐ ☐☐

MEMBER I.D. FROM YOUR ASSURE CARD

**Complete only if you are making a claim under your Health Spending Account.**

4. **Health Spending Account - (if included in your plan)**

Your Health Spending Account can be used for eligible expenses that qualify for the medical expense tax credit under the Income Tax Act. This may include expenses not covered under your Extended Health Care coverage.

Do you want your Health Spending Account to pay any unpaid portion of this claim? No ☐ Yes ☐

## Authorization and Signature

**You must complete this section.**

### For Health Spending Account Claims: (if included in your plan)

- I certify that expenses claimed qualify for reimbursement under my Health Spending Account.
- I understand that expenses for which I am reimbursed under my Health Spending Account cannot be claimed for Income Tax purposes (except in Quebec where special rules apply). I also acknowledge that the persons for whom I am making a claim are eligible and include myself, my spouse and any dependents for whom I am eligible to claim a medical expense tax credit as defined in the Income Tax Act. I understand that should any tax consequences arise from reimbursement of these expenses, I am responsible for payment of such taxes.

### For Extended Health Care and Health Spending Account Claims:

- I certify that the statements in this claim are true and complete and do not contain a claim for any expenses previously paid for by this or any other plan. I authorize the following to exchange information needed for underwriting, administration or paying claims: Sun Life Assurance Company of Canada; any person or organization who has relevant personal information about me and my minor dependents (if any), including health professionals, institutions, and insurers; and persons performing services for Sun Life.

| | |
|---|---|
| Member Signature | Date Day / Month / Year |

Mail the completed form to the Sun Life claims office for the region in which you live:

**EASTERN REGION**

**Atlantic Canada, Quebec and Eastern Ontario**

Sun Life of Canada
Health Claims Office
PO Box 6076 Stn CV
Montreal QC H3C 4S3
**(514) 866-3506**
**1-800-361-2128**

**CENTRAL REGION**

**Ontario (except Eastern Ontario)**

Sun Life of Canada
Health Claims Office
PO Box 4023 Stn A
Toronto ON M5W 2P7
**(416) 753-4300**
**1-800-361-6212**

**WESTERN REGION**

**Western Canada, N.W.T. and Yukon**

Sun Life of Canada
Health Claims Office
PO Box 2880 Stn Main
Edmonton AB T5J 4S6
**(780) 441-4400**
**1-800-661-7334**