Medical Claim Form
Only for International Students – Group no. 50659

Sun Life Financial

- 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.
- Sign on page 2 and mail your claim to the address at the bottom of page 2.

Clear

1 Student's statement – *complete in full to avoid delay of payment*

Contract number	Student ID number	Preferred language of correspondence
50659		☐ English ☐ French

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

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

If dental accident, we require X-rays taken after the accident and prior to treatment (if any).

Is this claim for services required as the result of an accident?	Where did the accident occur?	Date of the accident (yyyy-mm-dd)
☐ Yes ☐ No	☐ Home ☐ Work ☐ Other _____	_ _

How did the accident occur?

2 Claim for dependents – *complete this section only if claim is for a dependent*

Claims must first be submitted under the relevant plan or contract then to Sun Life, along with a copy of the settlement.
N.B.: Children must claim under the plan of parent with the earlier day and month of birth in the calendar year.

Dependent name		Date of birth (yyyy-mm-dd)	Relationship to you spouse son daughter	Full-time student	Disabled
Last name	First name	_ _	☐ ☐ ☐	☐ Yes ☐ No	☐ Yes ☐ No
Last name	First name	_ _	☐ ☐ ☐	☐ Yes ☐ No	☐ Yes ☐ No
Last name	First name	_ _	☐ ☐ ☐	☐ Yes ☐ No	☐ Yes ☐ No

If this claim includes expenses for a child over age 21, who is a student, please give the name of the educational institution in question.

Is spouse covered for any of these expenses under any medical plan or contract (including any insurance prepayment, service type, government plan or Workers' Compensation)? ☐ Yes ☐ No ☐ Not applicable If yes, complete the following:

Spouse's last name	First name	Date of birth (yyyy-mm-dd)
		_ _

Name of employer	Name of Group Medical carrier

3 Expenses

If your claim includes expenses for prescription drugs, please indicate the name of the drug or medication for each prescription number. This may be omitted if the name of the drug appears on the drug receipt.

Provider of service	Type of service	Date of service (yyyy-mm-dd)	Charge	Nature of illness
		_ _	$	
		_ _	$	
		_ _	$	
		_ _	$	

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3 Expenses (continued)

Prescription no.	Name of drug	Prescription no.	Name of drug	Prescription no.	Name of drug

If this information is left blank, your request for reimbursement will be processed according to the information provided.

Payment of Benefits – Important

Did you pay for the expenses you are claiming?

☐ **Yes The reimbursement cheque will be made in your name.**

☐ **No The reimbursement will be made in the name of the doctor, hospital or the provider.**

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 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.

Student's signature **(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 email 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 our toll-free number 1-800-361-6212 Monday - Friday, 8 a.m. - 8 p.m. ET

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5 Physician's/Surgeon's statement

Init.	Physician's last name	First name	Number	Group	Date (yyyy-mm-dd)	Treatment codes	R	Mod.	Units	Fees
					— —					$

Address (street number and name)	Apartment or suite	Date (yyyy-mm-dd)	Treatment codes	R	Mod.	Units	Fees
MANDATORY		— —					$

City	Province	Postal code	Date (yyyy-mm-dd)	Treatment codes	R	Mod.	Units	Fees
MANDATORY			— —					$

☐ General practitioner ☐ Specialist Field of specialization:			SC	Distance	Fees
					$

Referrer's last name	First name	Referrer's number	Date (yyyy-mm-dd)	Visits	Code	No.	Fees
			— —				$

Primary diagnosis and additional information	Diagnosis code	Date (yyyy-mm-dd)	Visits	Code	No.	Fees
MANDATORY	☐ ☐ ☐ ☐	— —				$
		Date (yyyy-mm-dd) — —	Visits	Code MANDATORY	No.	Fees $
		Date (yyyy-mm-dd) — —	Visits	Code	No.	Fees $

Code	Institution date admitted (yyyy-mm-dd)	Date discharged (yyyy-mm-dd)	**TOTAL** $
	— —	— —	

I certify that I provided the treatment referred to above.

Signature of Doctor or Authorized Agent	Date (yyyy-mm-dd)
X	— —

Mail your completed form to:

Sun Life Assurance Company of Canada
PO Box 11658 Stn CV
Montréal QC H3C 6C1

Sun Life Assurance Company of Canada will send a cheque and explanation of benefits directly to you or the assignee at the address you indicate on the reverse side of this form. Please ensure that you provide your full mailing address.

For questions concerning the coverage, contact the Group Benefits Customer Care Centre at 1-800-361-6212.

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