studentcare .net/works

Extended Health Care Claim Form

Sun Life Financial

- Sun Life Assurance Company of Canada, a member of the Sun Life Financial group of companies, is committed to keeping your information confidential.
- 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 studentcare.net

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	
Last name	First name	☐ Male ☐ Female	Date of birth (d/m/y)
Address (street number and name, apartment or suite)		City	
Province	Postal code	Do you prefer correspondence in ☐ English ☐ French	Telephone number ( )

2 Are you or your spouse covered under another plan?

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 (d/m/y)
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	Date (d/m/y)
X	

► **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're 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 (dd/mm/yy)	Relationship to you	Full-time student	Disabled	Amount claimed
Claimant (last name, first name)			☐ Yes ☐ No	☐ Yes ☐ No	$
Claimant (last name, first name)			☐ Yes ☐ No	☐ Yes ☐ No	$
Claimant (last name, first name)			☐ Yes ☐ No	☐ Yes ☐ No	$
Claimant (last name, first name)			☐ Yes ☐ No	☐ Yes ☐ No	$
Claimant (last name, first name)			☐ Yes ☐ No	☐ Yes ☐ No	$
					Total claimed $

► **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.

Fraudulent claims are very costly for all participants in benefit plans. As Administrator of this plan, we may check the accuracy of the information given in support of your claim.

Note for Members: As part of the benefits payment and plan management process, we exchange information about claims with you, including claims for goods or services received by your spouse and dependents. This includes details such as the date of the claim, what the claim was for, and the amount of the claim. **Please ensure that your spouse and/or dependents are aware of, and consent to this process prior to submitting claims.**

I certify that all goods or services being claimed have been received by me, and if applicable, my spouse and/or dependents. 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.

I authorize Sun Life Assurance Company of Canada, its agents and service providers to use and exchange information about me, and if applicable, my spouse and/or dependents, needed for underwriting, administration and adjudicating claims under this Plan with any other person or organization who has relevant information pertaining to this claim including health professionals, institutions, investigative agencies, insurers and reinsurers. I understand that information pertaining to this claim may be reviewed in the event this Plan is audited.

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 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 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.

Signature of Insured Student **(Mandatory)**	Date (d/m/y)
X	

5 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
Health Claims Office
PO Box 2641 Stn Main
Edmonton AB T5J 0A6