Assignment of Benefits to Health Care Provider

Sun Life Financial

- Use this form for an assignment of eligible expenses.
- Please print clearly and be sure all sections are complete to avoid delays in processing your claim.
- Your Health Care Provider must agree to be paid directly by Sun Life Assurance Company of Canada before you submit this form.
- 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.

1 Information about you – *be sure to fully complete this section*

Contract number	Member ID number	Your plan sponsor/employer	Preferred language of correspondence ☐ 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

2 Assignment of benefits to a Health Care Provider

This section must be completed in full by the Health Care Provider. Please remember to attach all itemized receipts.

Provider Information

Date of service (yyyy-mm-dd)	Provider name

Practitioner's last name	Practitioner's first name

Address (street number and name)

City	Province	Postal code

Signature or stamp of provider
X

3 Details of claim for Health Care Provider

List the names of all persons for whom you are claiming expenses. Add up all the receipts and insert the total amount claimed. Ensure each receipt clearly indicates the type of expense being claimed.

Person for whom you are making the claim		Date of birth (yyyy-mm-dd)	Relationship to you	Full-time student	Disabled	Amount claimed
Last name	First name			☐ Yes ☐ No	☐ Yes ☐ No	$
Last name	First name			☐ Yes ☐ No	☐ Yes ☐ No	$
Last name	First name			☐ Yes ☐ No	☐ Yes ☐ No	$
Last name	First name			☐ Yes ☐ No	☐ Yes ☐ No	$
						Total claimed $

4 Assignment of benefits, authorization and signature – *you must complete this section*

Assignment of Benefits

Benefits can only be assigned to providers approved by the Administrator of the Plan. For more details, please contact the Plan Administrator.

I hereby assign my benefits payable from this claim to the above named provider and authorize payment directly to the provider. ☐ Yes ☐ No

If yes, I hereby assign my benefits payable for the eligible claims submitted in the attached claim form to the named Health Provider and in the event that my claim is approved, I authorize payment directly to them. In the event that my claim is declined under my plan sponsor's benefit plan, I agree that I remain responsible to pay the Health Provider for any services rendered. I acknowledge and agree that any payment of benefits made in accordance with this assignment will validly discharge Sun Life Assurance Company of Canada of its obligations under the Plan. In the event that payment is made to me, Sun Life Assurance Company of Canada is also discharged of its obligations under the Plan, regardless of whether the benefit payment was subject to this Assignment.

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.

Member's signature	Date (yyyy-mm-dd)
X	

5 Respecting your privacy

Respecting your privacy is a priority for the Sun Life Financial group of companies. We keep in confidence personal information about you and the products and services you have with us to provide you with investment, retirement and insurance products and services to help you meet your lifetime financial objectives. To meet these objectives, we collect, use and disclose your personal information for purposes that include: underwriting; administration; claims adjudication; protecting against fraud, errors or misrepresentations; meeting legal, regulatory or contractual requirements; and we may tell you about other related products and services that we believe meet your changing needs. The only people who have access to your personal information are our employees, distribution partners such as advisors, and third-party service providers, along with our reinsurers. We will also provide access to anyone else you authorize. Sometimes, unless we are otherwise prohibited, these people may be in countries outside Canada, so your personal information may be subject to the laws of those countries. You can ask for the information in our files about you and, if necessary, ask us in writing to correct it. To find out more about our privacy practices, visit www.sunlife.ca/privacy.

Questions? Please visit www.sunlife.ca or call toll-free 1-800-361-6212 Monday - Friday, 8 a.m. - 8 p.m. ET

Mailing instructions – *keep a copy of your claim form and receipts for your records*

Mail your completed form to the claims office nearest you.

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of Canada
PO Box 11658 Stn CV
Montreal QC H3C 6C1

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of Canada
PO Box 2010 Stn Waterloo
Waterloo ON N2J 0A6