Extended Health Care and Health Spending Account Claim Form

Sun Life

- Use this form for **all** medical expenses and services. For dental expenses, please use the *Dental and Health Spending Account Claim 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.
- Sign on page 2 and mail your claim to the address at the bottom of page 2. Some plans allow claims to be submitted online at **www.sunlife.ca.**

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

Contract number	Member ID number	Your plan sponsor/employer	Preferred language of correspondence
14098		**York University**	☐ English ☐ French

Your last name	First name	Date of birth (yyyy-mm-dd)	Daytime phone number
		– –	– –

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

2 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 a member of another benefit plan? ☐ No ☐ Yes If yes, please provide details below.

Spouse's last name	First name	Date of birth (yyyy-mm-dd)	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 benefit plan is with Sun Life Financial, do you want us to process the claim through both benefit plans? ☐ No ☐ Yes	Contract number	Member ID number

Spouse's signature	Date (yyyy-mm-dd)
X	– –

Are you also a member of another benefit 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 ☐ Retired	If your other benefit plan is with Sun Life Financial, do you want us to process the claim through both benefit plans? ☐ No ☐ Yes	Contract number	Member ID number

3 Complete this section only if you have a Health Spending Account (HSA)

If you're covered under more than one benefits plan, you should consider submitting your claim to the other plan(s) before using your HSA. If you are using your HSA to claim for the unpaid amount previously submitted to this or another plan, attach the claim statement you received and a copy of the receipts. Please select one of the following:

☐ You **don't** want to use your HSA for this claim.

☐ You want us to assess this claim under your Extended Health Care benefit **first** and then assess any unpaid balance under your HSA.

☒ You want us to assess this claim under your HSA **only.**

4 Information about your claim

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	$

For SLF use: HCF

4 Information about your claim – *continued*

Are you attaching receipts for out-of-Canada expenses? ☐ No ☐ Yes

If yes, tell us the date of departure from claimant's home province. Ensure the currency and amount are clearly marked on each receipt. We'll assess your claim and convert the eligible expenses to Canadian dollars.

Date (yyyy-mm-dd)	Out-of-Canada expenses claimed
– –	$
Country where the services were rendered	**Currency used for payment**

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

5 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.

If I am making a claim under my Health Spending Account, I certify that these expenses qualify for reimbursement.

I also acknowledge that the persons for whom I am making a claim are eligible and include myself, my spouse and any dependents as defined under the Health Spending Account coverage. I understand that should any tax consequences arise from reimbursement of these expenses, I am responsible for payment of such taxes. I also understand that my plan sponsor may have access to a summary of the total amounts claimed by me under my Health Spending Account for the purposes of tax or administrative reporting.

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	– –

Respecting your privacy

Our Purpose is to help our Clients achieve lifetime financial security and live healthier lives. We collect, use and disclose your personal information to: develop and deliver the right products and services; enhance your experience and manage our business operations; perform underwriting, administration and claims adjudication; protect against fraud, errors or misrepresentations; tell you about other products and services; and meet legal and security obligations. We collect it directly from you, when you use our products and services, and from other sources. We keep your information confidential and only as long as needed. People who may access it include our employees, distribution partners such as advisors, service providers, reinsurers, or anyone else you authorize. At times, unless we're prohibited, they may be outside your jurisdiction and your information may be subject to local laws. You can always ask for your information and to correct it if needed. In most cases, you have a right to withdraw your consent, but we may not be able to provide the requested product or service. Read our Global Privacy Statement and local policy at *www.sunlife.ca/privacy* or call us for a copy.

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

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
PO Box 11658 Stn CV
Montreal QC H3C 6C1

For SLF use:
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