



Claim Form



Sections 1 to 3 must be completed by the member; Sections 4 and 5 must be completed by the provider. Attach ORIGINAL bills from the provider or receipts indicating that you have paid the provider in full (photocopied bills/receipts are not acceptable). Remember to indicate your member identification number, and sign and date the AUTHORIZATION section.

Policy numbers Sun Life Assurance Company of Canada – 50150 American Home Assurance Company – SRG9114277

Your privacy is important to us. To view Sun Life Financial’s privacy policy please refer to www.sunlife.ca or to the UHIP® booklet “University Health Insurance Plan (UHIP®) your basic health care solution” which can be found at www.uhip.ca.

All claims must be submitted to Sun Life Assurance Company of Canada at the address below no more than TWELVE MONTHS following the date on which the expenses are incurred.

Please PRINT clearly.

1 Member information

University name		Member identification number	
Last name		First and middle names	
Date of birth (d/m/y)	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Telephone # ()	Email address
Canadian address (street number and name, apartment or suite)			
City	Province	Postal code	

2 Patient information

Last name	First name		
Date of birth (d/m/y)	Relationship to member	<input type="checkbox"/> Member	<input type="checkbox"/> Son
		<input type="checkbox"/> Spouse	<input type="checkbox"/> Daughter

3 Authorization and signature

Personal Information Notice

I understand that the information provided by me on this claim form and otherwise in respect of my claim, is required by Sun Life Assurance Company of Canada and American Home Assurance Company, their reinsurers and authorized administrators (the “Insurers”) to assess my entitlement to benefits as well as to administer and underwrite claims, including but not limited to determining if coverage is in effect, investigating the applicability of exclusions and coordinating coverage with each other and other insurers. For these purposes, the Insurers will also consult their existing insurance files about me, collect additional information about and from me, and where required, collect information from and exchange information with, third parties.

Certification

The statements I provide in completing this claim form and otherwise in respect of my claims are true and complete to the best of my knowledge and belief. In the event of a false or misleading statement in the making of this claim, coverage can be cancelled, payment of benefits denied and past claims payments recovered. I agree to refund to the Insurers, the amount of any payments made in the event that such amounts should not have been paid in respect of my claim.

Authorization

I authorize, for a period of not less than twelve and not more than twenty-four months from the date hereof, any physician, practitioner, health care provider, hospital, health care institution, medical organization, clinic and any other medical or medically related facility, any insurance company or reinsurance company, workers compensation board or similar plan or organization, UHIP plan administrator, federal, territorial or provincial government department, or any other corporation or organization, institution or association (including obtaining information from the group policyholder or my employer) to release and exchange with Sun Life Assurance Company of Canada and American Home Assurance Company, their agents, service providers or representatives, all personal health information, benefit payment, employment or financial information about me or any other information or records about me in its possession that is requested while administering my claim.

