UHIP Claim form

All claims must be received by Sun Life within TWELVE MONTHS of the service date. Sun Life Assurance Company of Canada is the insurer and a member of the Sun Life group of companies.

1 UHIP member information

University name	Policy number **50150**	UHIP member identification number
Last name	First name	Date of birth (dd-mm-yyyy) _ _
Telephone number _ _	University email address	
Canadian address (street number and name)		Apartment or suite
City	Province	Postal code

If you or your dependents have other health coverage with Sun Life or another insurer, please provide details below.

Name of insurer	Policy number	Member identification number

2 Claimant information

Last name	First name
Date of birth (dd-mm-yyyy) _ _	Relationship to UHIP member ☐ Member ☐ Spouse ☐ Child

3 UHIP member authorization

I authorize the healthcare provider/clinic named above to submit claims on my behalf and my dependents (if applicable) to Sun Life Assurance Company of Canada (Sun Life).

I authorize Sun Life, its agents and services providers and as applicable the plan administrators to collect, use and exchange information needed for underwriting, administration, adjudicating claims and claims management under this insurance coverage. This information can be shared with any person or organization who has relevant information about me including health professionals, government agencies, provincial health care plan, institutions, investigative agencies insurers, re-insurers and, as applicable, the plan sponsor and plan administrator.

If there is suspicion of fraud and/or abuse related to my claim, I understand and agree that Sun Life, its agents and service providers may exchange information about my claim for the purpose of investigation and prevention of fraud and/or abuse with any relevant organization, including as applicable the plan sponsor and plan administrator, law enforcement bodies, regulatory bodies, government organizations and other insurers.

If there is an overpayment, I authorize the recovery of the full amount of the overpayment from any amount payable to me.

If I am submitting claims for my spouse and/or dependents, I confirm that I am authorized by them to disclose personal information about them for the purposes described above to Sun Life, its agents and services providers and any person or organization who has relevant information about them including health professionals, government agencies, provincial health care plan, institutions, investigative agencies insurers, re-insurers and, as applicable, the plan sponsor and plan administrator.

HCF

3 Authorization (continued)

Check one of the following boxes:

☐ Payment is to be made to the member (submit all receipts (proof of payment) with claim form. Keep copies for your record)

☐ Payment is to be made directly to the provider (Physician or Nurse Practitioner)

☐ Payment is to be made to the facility (hospital/lab/Med Prof Corp/Clinic)

Member's signature (digital or original)	Date (dd-mm-yyyy)
X	– –

4 Provider/Facility information

This section needs to be fully completed in the absence of an invoice with the same information.

Clinic/Hospital/Lab/Med Prof Corp name	Physician's name	Nurse practitioner's name

Address of provider (street number, suite and name)	City	Province	Postal code	Telephone number
				– –

5 Statement of services

This section needs to be fully completed in the absence of an invoice with the same information.

Service date (dd-mm-yyyy)	Description of service	OHIP procedure code	Time units, if applicable	Total claim cost	Diagnosis or reason for visit
– –				$	
– –				$	
– –				$	

I declare that the above is a correct statement of the services rendered.

Provider's signature (required only in absence of an invoice.)	Date (dd-mm-yyyy)
X	– –

6 Respecting your privacy

Respecting your privacy is a priority for the Sun Life 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*.

How to submit your completed claim form

UHIP Members: From your **University email account**, you can email us your claim form and receipts to *myclaims@sunlife.com*. Email subject line should include: #50150 and the UHIP Member ID.

Health Care Providers: Email us the claim form and receipts to *myclaims@sunlife.com*. ONLY one member claim per email. Email subject line should include: #50150 and the UHIP Member ID.

Although Sun Life uses reasonable means to protect the security and confidentiality of the email content it sends and receives, should you choose to send us your claim form by email, the privacy or security of your email communication cannot be guaranteed.

Mail us your claim form and receipts to:
Sun Life Assurance Company of Canada
Claims Department PO Box 2015 STN Waterloo, Waterloo ON N2J 0B1

Contact us

We're here to answer your questions Mon to Fri 8:00 a.m. to 8:00 p.m. ET

UHIP Members: Call us at 1-866-500-8447

Health Care Providers: Call us at 1-855-301-4786 and follow the prompts. When asked for the member contract #, enter the pound key (#) 3 times to reach a representative.