

# Assignment of Benefits to Health Care Provider



- 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<br><input type="checkbox"/> English <input type="checkbox"/> French |             |
| Your last name                        |                  | First name                 | <input type="checkbox"/> Male<br><input type="checkbox"/> 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<br>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 | — —                        |                     | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | \$                         |
| Last name                                | First name | — —                        |                     | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | \$                         |
| Last name                                | First name | — —                        |                     | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | \$                         |
| Last name                                | First name | — —                        |                     | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | \$                         |
|  |            |                            |                     |   |   | <b>Total claimed</b><br>\$ |

**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<br>X | Date (yyyy-mm-dd)<br>— — |
|-------------------------|--------------------------|

**Respecting your privacy**

Your privacy is important to us. We may leverage our strengths in our worldwide operations and in our negotiated relationships with third-party providers to help us service some of our customers. In some instances our employees, service providers, agents, reinsurers and any of their service providers, may be located in jurisdictions outside Canada, and your personal information may be subject to the laws of those foreign jurisdictions.

To find out about our Privacy Policy, visit our website at [www.sunlife.ca](http://www.sunlife.ca), or to obtain information about our privacy practices, send a written request by email to [privacyofficer@sunlife.com](mailto:privacyofficer@sunlife.com), or by mail to Privacy Officer, Sun Life Financial, 225 King St. West, Toronto, ON M5V 3C5.

**Questions?** Please visit [www.sunlife.ca](http://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 the claims office nearest you. | Sun Life Assurance Company of Canada<br>PO Box 11658 Stn CV<br>Montreal QC H3C 6C1 | Sun Life Assurance Company of Canada<br>PO Box 2010 Stn Waterloo<br>Waterloo ON N2J 0A6 |
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