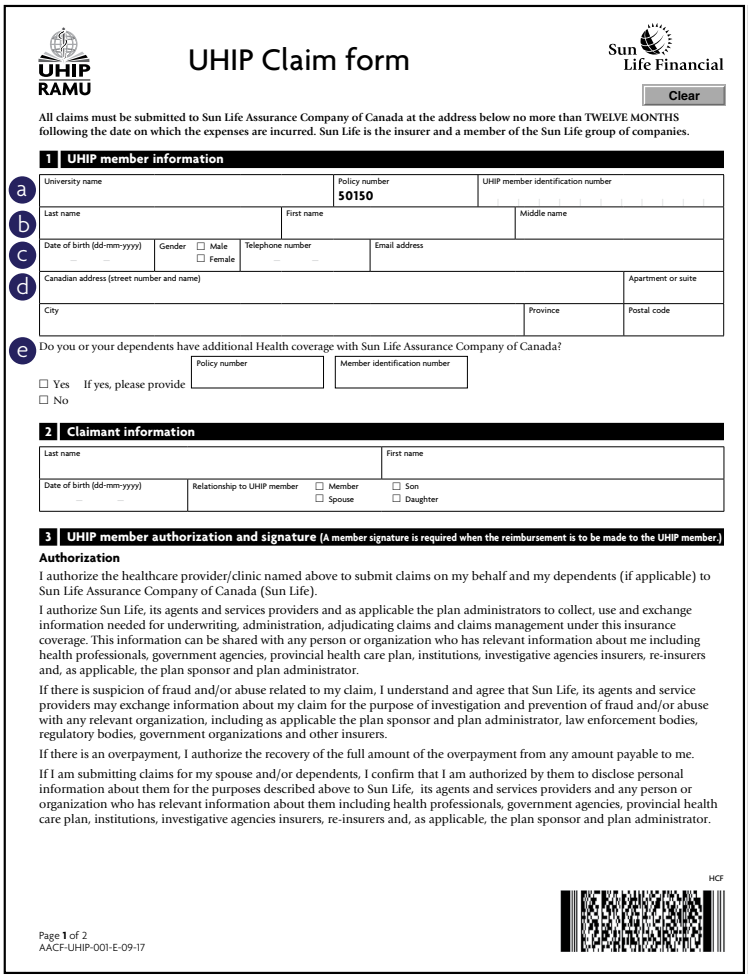
How to complete the UHIP Claim form

- Read the introduction carefully, and follow the instructions.
- Fill out electronically or print clearly in pen, using block letters.
- Enter all dates numerically (2 numbers each for day and month, 4 numbers for year).
- Once completed, send to Sun Life. Please see mailing instructions on the bottom of page 2.



UHIP RAMU

UHIP Claim form

Sun Life Financial

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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. Sun Life is the insurer and a member of the Sun Life group of companies.

1 UHIP member information

a) University name | Policy number: 50150 | UHIP member identification number

b) Last name | First name | Middle name

c) Date of birth (dd-mm-yyyy) | Gender ☐ Male ☐ Female | Telephone number | Email address

d) Canadian address (street number and name) | Apartment or suite

City | Province | Postal code

e) Do you or your dependents have additional Health coverage with Sun Life Assurance Company of Canada?

☐ Yes If yes, please provide Policy number | Member identification number

☐ No

2 Claimant information

Last name | First name

Date of birth (dd-mm-yyyy) | Relationship to UHIP member ☐ Member ☐ Spouse ☐ Son ☐ Daughter

3 UHIP member authorization and signature (A member signature is required when the reimbursement is to be made to the 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.

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3 Authorization and signature (continued)

Important

Check one of the following boxes:

☐ Payment is to be made to the member **(Member signature is required below). Enclose all receipts (proof of payment) with your submission and keep a copy for your records.**

☐ Payment is to be made directly to the provider **(Member signature NOT required)**

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

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*.

4 Provider information

Section 4 and 5 requires completion in the absence of an invoice with all the same information present. Any missing information will result in a declined claim.

Clinic/Hospital or Lab name | Physician's name

Address of provider (street number and name) | Apartment or suite

City | Province | Postal code | SLF Provider ID number **(if known)** | 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 (plus 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 (A signature is required only in absence of an invoice.): X | Date (dd-mm-yyyy)

Please mail completed form and supporting documents to:

Sun Life Assurance Company of Canada
Claims Department
PO Box 2015 STN Waterloo
Waterloo ON N2J 0B1

Members may direct all claim inquiries to the toll free phone number: 1-866-500-UHIP (8447)

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Section 1: UHIP member information

a) Provide the name of the University you are attending and your UHIP member identification number.

b) Provide your full name (last, first, and middle).

c) Provide your date of birth, gender, telephone number and email address.

d) Provide your Canadian address, including postal code.

e) Complete this section only if you have another insurance policy with Sun Life.

Section 2: Claimant information

The 'claimant' is the person who is receiving the medical service. All information under section 2 needs to be completed.

Section 3: Authorization and signature

If you have paid for the service (check off the box: Payment is to be made to the member). You need to sign your name under 'member's signature' below. The completed claim form with proof of payment and the information in the statement of services (see section 5) may be mailed to the address listed at the bottom of the document. There is no web site service for members to submit their claims.

Section 4: Provider information

This section is to be completed by the Physician only if they do not provide a statement of services (an invoice with: a service date, description of service, OHIP procedure code (s), total claim cost and diagnosis or reason for visit).

Section 5: Statement of services

The Physician needs to complete this section in the absence of an invoice.

A provider (Physician) signature is required only in the absence of an invoice.