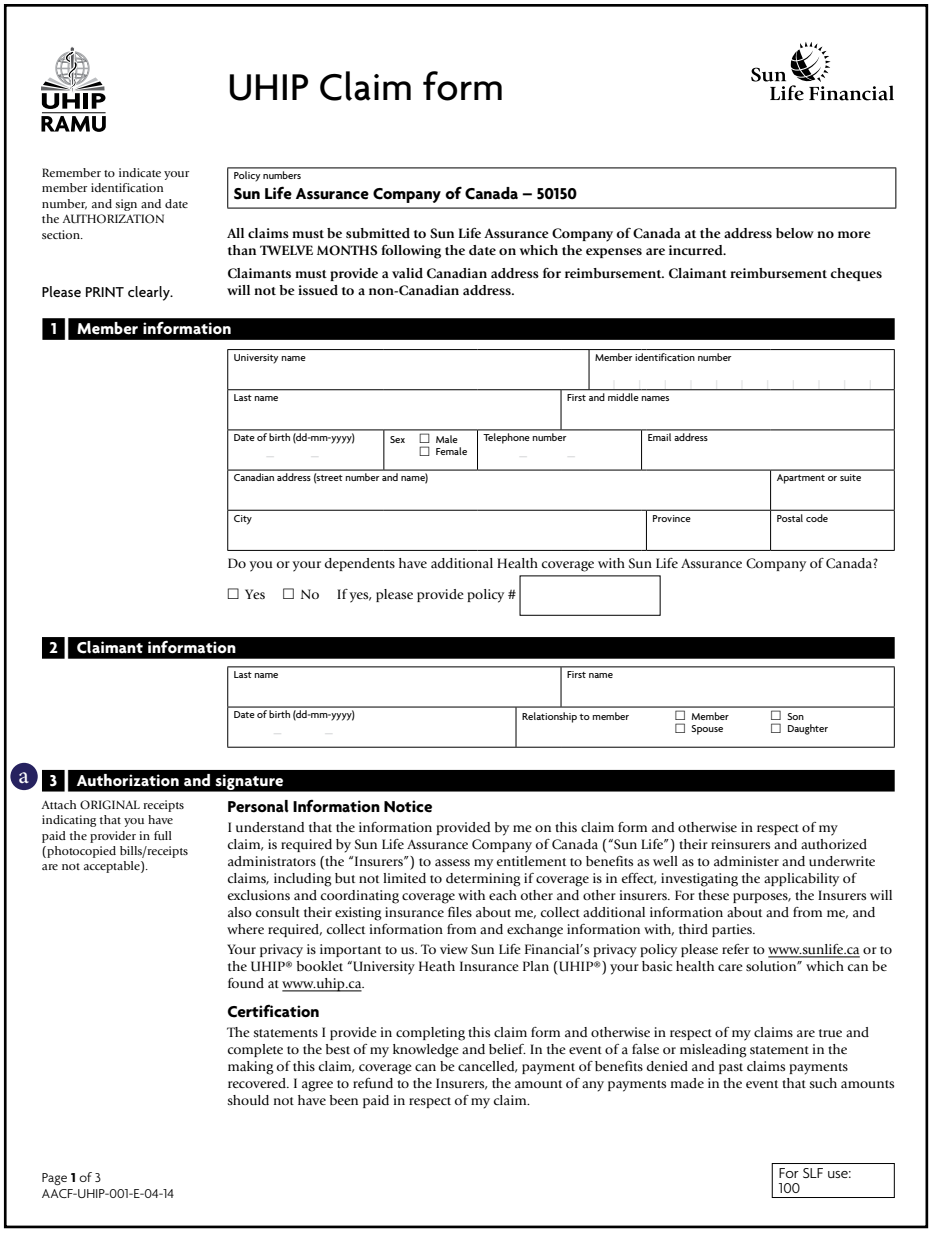
Instructions on how to complete a UHIP Claim Form

- Print clearly in pen, using block letters.
- Enter all dates numerically (4 numbers for year, 2 numbers each for month and day).
- Once completed, return the form to the UHIP®-UPA.



UHIP RAMU

UHIP Claim form

Sun Life Financial

Remember to indicate your member identification number, and sign and date the AUTHORIZATION section.

Please PRINT clearly.

Policy numbers
Sun Life Assurance Company of Canada – 50150

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.

Claimants must provide a valid Canadian address for reimbursement. Claimant reimbursement cheques will not be issued to a non-Canadian address.

1 Member information

University name			Member identification number
Last name		First and middle names	
Date of birth (dd-mm-yyyy)	Sex ☐ Male ☐ Female	Telephone number	Email address
Canadian address (street number and name)			Apartment or suite
City		Province	Postal code

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

☐ Yes ☐ No If yes, please provide policy #

2 Claimant information

Last name	First name
Date of birth (dd-mm-yyyy)	Relationship to member ☐ Member ☐ Spouse ☐ Son ☐ Daughter

a **3 Authorization and signature**

Attach ORIGINAL receipts indicating that you have paid the provider in full (photocopied bills/receipts are not acceptable).

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 ("Sun Life") 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.

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 Heath Insurance Plan (UHIP®) your basic health care solution" which can be found at www.uhip.ca.

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.

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For SLF use:
100

Section 1 (Member information) to Section 3 (Authorization of signature)

- Clearly indicate if reimbursement is to be made to the member or provider.

Section 1: Member Information

a) University name and UHIP® member identification number

b) Full name: last, first and middle

c) - Your date of birth
- Your gender
- Your telephone number
- Your email address

d) Your complete Canadian residential address, including city, province and postal code.

e) If you answer yes to this question please provide you or your dependents policy #.

Section 2: Claimant Information

a) The first and last name of the claimant

b) - The birth date of the claimant
- Please choose one of the choices to specify your relationship to the claimant

Section 3 (Authorization of signature)

a) Remember to indicate your member identification number and ensure you sign and date

3 Authorization and signature (continued)

This section is to only be completed when reimbursement is to be made directly to claimant.

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, Plan Sponsor, 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 their agents, service providers or representatives, all personal health information, benefit payment, employment or financial information about me, my spouse and/or dependents, or any other information or records about me, my spouse and/or dependents, in its possession that is requested while administering this claim.

I understand that for audits and administrative reporting, the Plan Sponsor or UHIP plan administrator of this coverage may have access to statistical and financial information without any personal identifiers. I agree that a reproduction of this authorization shall be as valid as the original.

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 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.

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.

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.

Important

Check one of the following boxes:

☐ Payment is to be made to the member.
☐ Payment is to be made directly to the provider.

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

4 Provider information

Section 4 and 5 is to only be completed by the provider when reimbursement is to be made directly to provider.

Provider's name	Physician's name	
Address of provider (street number and name)		Apartment or suite
City	Province	Postal code
SLF Provider ID number	Telephone number – –	

5 Statement of services (Physicians and hospitals must provide the diagnosis.)

Service date (dd-mm-yyyy)	Description of service	OHIP procedure code (plus time units, if applicable)	Charge	Diagnosis
– –				
– –				
– –				
– –				
– –				
– –				

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

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

DIRECT ALL CLAIMS AND INQUIRIES TO:

You must provide your UHIP member ID when contacting us by telephone.

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

Toll free: 1-866-500-UHIP (8447)

Section 4 (Provider information) to Section 5 (Statement of services)

- Completed by the provider clearly indicating diagnosis

Attach all ORIGINAL bills from the provider or RECEIPTS indicating you have paid the provider in full.
Please note that photocopied bills or receipts are not acceptable.

Forms should be mailed to:

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

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Sun Life Assurance Company of Canada
Toll Free: 1-866-500-UHIP (8447)