Gender Affirmation Claim form

Sun Life

Instructions for this form:

- Use this form for **all** medical expenses and services.
- Please print clearly and be sure all sections are complete to avoid delays in processing your claim.
- Attach the **original** receipt for each expense claimed and keep photocopies for your records.
- Sign on page 3 and mail your claim to the address at the bottom of page 2. Some plans allow claims to be submitted online at *www.sunlife.ca*.

Instructions for assignments (see section 4 of this form):

- If you're assigning benefits to a health provider, then you'll need a separate form for each provider.
- The primary member and the health provider need to sign this form.
- The health provider must agree to be paid directly by Sun Life Assurance Company of Canada (Sun Life) before you submit this form. You will be responsible for any amounts not covered by your benefits plan.

Clear

1 Information about you – *be sure to fully complete this section*

Contract number	Member ID number	Your plan sponsor/employer	Preferred language of correspondence ☐ English ☐ French
Your last name	First name	Date of birth (yyyy-mm-dd)	Daytime phone number
Your address (street number and name)	Apartment or suite	City	Province / Postal code

2 Complete this section if you or your spouse are covered under another plan

Send your claims to your own plan first. When you receive your claim statement, send a copy plus copies of your receipts to your spouse's plan to claim any unpaid amount.

Send your spouse's claims to their plan first, then send a copy of their claim statement and receipts to your plan.

Send your children's claims first to the plan of the parent whose birthday falls earlier in the year.

Is your spouse a member of another benefit plan? ☐ Yes ☐ No If yes, please provide details below.

Spouse's last name	First name	Date of birth (yyyy-mm-dd)	Type of coverage ☐ Single ☐ Family
Are you claiming any expenses that are **NOT** covered under your spouse's plan? ☐ No ☐ Yes If yes, please specify:			
If your spouse's benefit plan is with Sun Life, do you want us to process the claim through both benefit plans? ☐ No ☐ Yes		Contract number	Member ID number
Spouse's signature X			Date signed (yyyy-mm-dd)

Are you also a member of another benefit plan? ☐ Yes ☐ No If yes, please provide details below.

Type of coverage ☐ Single ☐ Family	Are you claiming any expenses that are **NOT** covered under your other plan? ☐ No ☐ Yes If yes, please specify:		
What is your employment status under your other benefits plan? ☐ Full-time ☐ Part-time ☐ Retired	If your other benefit plan is with Sun Life, do you want us to process the claim through both benefit plans? ☐ No ☐ Yes	Contract number	Member ID number

3 Information about your claim

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: Last name	First name	Date of birth (yyyy-mm-dd)	Relationship to you	Amount claimed
				$
				Total claimed $

For SLF use:
HCF

4 Assignment of benefit payee

The provider/facility needs to complete this section.

The plan member and health provider acknowledge that:

- not all benefits plans allow for the assignment of benefits. The plan member should contact their Benefits Administrator to confirm that they can assign benefits.
- Sun Life may decline to pay the claim or refuse to pay the health provider.

The plan member must attach all itemized receipts and choose one of the following payees (this is the health provider that Sun Life will pay):

☐ Health care provider

☐ Health care facility

☐ Pharmacy

Section to be completed and signed by health provider

Request approval date (yyyy-mm-dd)	Provider's last name	Provider's first name

Designation/College registration number	Provider payee name

Address (street number and name)	Apartment or suite

City	Province	Postal code

- I agree that Sun Life can pay me directly instead of the patient.
- I further agree that if Sun Life doesn't pay all expenses related to the services set out in this form, then the patient must pay me. I agree that I'll have no recourse against Sun Life, even if Sun Life pays the plan member instead of me. A copy of my handwritten or typed signature, or my stamp will be as valid and binding as an original signature.

Signature or stamp of provider
X

5 Authorization and signature – *you must complete this section*

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.

If I assigned my benefit payments to the health provider(s) named in section 4, then I agree and understand to the terms for the assignment, as described in this section. I further agree that Sun Life's payment of eligible expenses to the health provider(s) will discharge Sun Life of its obligations under the Plan. For any amounts that Sun Life doesn't pay and/or for any claims that Sun Life declines, I agree that I'm responsible to pay the health provider for their services. If Sun Life pays me instead of the health provider(s), even if I've assigned the benefits, then Sun Life's payment discharges it of its obligations under the Plan and I agree that I'll be responsible to pay the health provider.

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	Date (yyyy-mm-dd)
X	

6 Respecting your privacy

Our Purpose is to help our Clients achieve lifetime financial security and live healthier lives. We collect, use and disclose your personal information to: develop and deliver the right products and services; enhance your experience and manage our business operations; perform underwriting, administration and claims adjudication; protect against fraud, errors or misrepresentations; tell you about other products and services; and meet legal and security obligations. We collect it directly from you, when you use our products and services, and from other sources. We keep your information confidential and only as long as needed. People who may access it include our employees, distribution partners such as advisors, service providers, reinsurers, or anyone else you authorize. At times, unless we're prohibited, they may be outside your jurisdiction and your information may be subject to local laws. You can always ask for your information and to correct it if needed. In most cases, you have a right to withdraw your consent, but we may not be able to provide the requested product or service. Read our Global Privacy Statement and local policy at *www.sunlife.ca/privacy* or call us for a copy.

Questions? Please visit *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
PO Box 11658 Stn CV
Montreal QC H3C 6C1

Sun Life Assurance Company
of Canada
PO Box 2010 Stn Waterloo
Waterloo ON N2J 0A6