Gender Affirmation Application form

Prior approval process

Sun Life Assurance Company of Canada, a member of the Sun Life group of companies, is committed to keeping your information confidential.

1 Important – please read carefully

Prior approval by Sun Life is required for surgical expenses or other gender affirmation procedures to be eligible for reimbursement. The completion of this form is not a guarantee that we will approve your expenses. We will send you our decision in writing. Please fully complete the form. You may be required to submit documents, at your own expense, to Sun Life to support this request.

To be eligible for coverage under this benefit, you must:

- be at least 18 years of age and
- have been diagnosed with gender dysphoria by a medical doctor

All surgical procedures and other treatments covered under this benefit must be performed in Canada. If you meet the criteria for coverage, we will pay your expenses according to the terms of your plan. Please see your plan member benefits booklet for details of your coverage.

2 To be completed by plan member

Plan member information

Contract number	Member ID number	Your plan sponsor/employer

Your last name	First name	Date of birth (dd-mm-yyyy)

Your address (street number and name)	Apartment or suite

City	Province	Postal code

Preferred language of correspondence	Daytime telephone number	Email address
☐ English ☐ French		

Claimant information

The claimant is the person for whom you are making the claim.

Last name	First name	Date of birth (dd-mm-yyyy)

Relationship to you
☐ Self ☐ Spouse ☐ Child

***This section must be signed and dated by the Plan member for this form to be processed.**

Authorization and signature

I certify that the information I provided above is true and complete. I authorize Sun Life Assurance Company of Canada, its agents and service providers to collect, use and disclose information needed for underwriting, administration and adjudicating claims under this Plan with any person or organization who has relevant information pertaining to this prior approval including health professionals, institutions, investigative agencies, insurers and reinsurers.

I agree that a photocopy or electronic version of this authorization shall be as valid as the original.

*Plan member's signature	*Date (dd-mm-yyyy)
X	

3 To be completed by prescribing physician

Prescribing physician's last name (please print)	First name (please print)	
License number		
Specialty		Telephone number
Address (street number and name)		Apartment or suite
City	Province	Postal code

Please confirm that:

☐ patient has a diagnosis of gender dysphoria,
☐ patient has the capacity to make a fully informed decision and to consent for treatment,
☐ patient has attained the age of majority in their province of residence, and
☐ if the patient has any significant medical or mental health concerns, then they are reasonably well-controlled.

Declaration

I declare that:

- this patient is under my care for gender transitioning and requires treatment,
- I've informed this patient of potential risks and benefits of gender-related treatment, and
- I've informed this patient of alternative therapies.

Physician's signature X	*Date (dd-mm-yyyy)

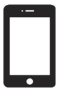
Respecting your privacy

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.

Send us your documents

All pages of this form and all required documents must be submitted together. Keep a copy for your records.



You can submit **all** pages of this form and all required documents through the mobile app by selecting "Estimates".

OR,

Mail all completed pages of the form and all required documents to the claims office nearest you.

Sun Life Assurance Company
of Canada
Attention: Claims Dept.
PO Box 11658 Stn CV
Montreal QC H3C 6C1

Sun Life Assurance Company
of Canada
Attention: Claims Dept.
PO Box 2010 Stn Waterloo
Waterloo ON N2J 0A6