ASU
Acadia Students' Union

Medical Care Claim Form for International Students

Sun Life Financial

Sun Life Assurance Company of Canada is the insurer, and is a member of the Sun Life Financial group of companies.

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.

Please PRINT clearly.

1 Member information

Policy number **017882**	Member ID number (9 digit Acadia student ID number)	Plan sponsor **The Campus Trust**	
Last name		First name	
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

2 Complete this section if you are covered under another plan

Are you covered by another plan? ☐ No ☐ Yes 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.	
If your other benefit plan is with Sun Life Financial, do you want us to process the claim through both benefit plans? ☐ No ☐ Yes	Contract number	ID number

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*.

Questions? Please visit ***www.sunlife.ca*** or call our toll-free number 1-888-206-9004 Monday - Friday, 8 a.m. - 8 p.m. ET

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.

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

Person for whom you are making the claim		Date of birth (dd-mm-yyyy)	Relationship to you (self, spouse, etc.)	Disabled	Amount claimed
Last name	First name			☐ Yes ☐ No	$
Last name	First name			☐ Yes ☐ No	$
					Total claimed $

Are you attaching receipts for out-of-Canada expenses? ☐ No ☐ Yes

If yes, tell us the date of departure from claimant's home province. Ensure the currency and amount are clearly marked on each receipt. We'll assess your claim and convert the eligible expenses to Canadian dollars.

Date (dd-mm-yyyy)	Out-of-Canada expenses claimed $

Are any of the expenses you're claiming the result of a work injury? ☐ No ☐ Yes

If yes, did you submit your claim to the workers' compensation plan in your province, if applicable? ☐ No ☐ Yes

Are any of the expenses you're claiming the result of a motor vehicle accident? ☐ No ☐ Yes

If yes, did you submit your claim to the automobile insurance plan in your province, if applicable? ☐ No ☐ Yes

For SLF use:
HCF

4 Authorization and signature

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.

Important

Check one of the following boxes: ☐ Payment is to be made to the member. ☐ Payment is to be made directly to the provider.

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

5 Provider information

Section 5 and 6 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
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6 Statement of services (Physicians and hospitals must provide the diagnosis.)

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

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

Toll free: 1-888-206-9004 You must provide your member ID when contacting us by telephone.