Health Spending Account Claim Form

Sun Life Financial

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

1 Member information – *be sure to fully complete this section*

Contract number	Member ID number	Your plan sponsor/employer	Preferred language of correspondence
150033		**The University of Western Ontario**	☐ English ☐ French

Your last name	First name	☐ Male ☐ Female	Date of birth (d/m/y)	Daytime phone number
				( )

Your address (street number and name, apartment or suite)	City	Province	Postal code

2 Payment under the Health Spending Account

Attach original receipts. OR If this claim has been submitted under another plan, attach the original Explanation of Benefits from that plan and copies of the receipts.

Your Health Spending Account can be used for eligible expenses that qualify for the medical/dental expense tax credit under the Income Tax Act. This may include expenses not covered under an Extended Health/Dental Coverage or unpaid portion of medical/dental expenses that have been submitted to another plan. See your information guide for a complete list.

Description of expenses	Year of expenses	Person for whom you are making the claim: Name	Relationship to member	Gender: Male	Gender: Female	Date of birth: Day	Date of birth: Month	Date of birth: Year	Amount
				☐	☐				
				☐	☐				
				☐	☐				
				☐	☐				
				☐	☐				

TOTAL AMOUNT CLAIMED ► $

If you or any person for whom you are making a claim has coverage under another plan, you should submit the claim to the other plan first. This procedure is to your advantage because your Health Spending Account is only used to pay for expenses not covered by other plans. If you do not know whether an expense is covered by your regular plan, we recommend that you send it to the other plan first. After the benefits have been paid by the other plan, you can then submit the unpaid portion of that claim for payment from your Health Spending Account.

3 Authorization and Signature – *you must complete this section*

I certify that all goods and services being claimed under my Health Spending Account 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.

I acknowledge that the persons for whom I am making a claim are eligible and include myself, my spouse and any dependents as defined under the Health Spending Account coverage.

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 use and exchange information about me, and if applicable, my spouse and/or dependents needed for underwriting, administration and adjudicating claims under this Plan with 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 exchange of information about this claim with other persons or organizations, including credit agencies and, where applicable, my Plan Sponsor for that purpose.

I understand that should any tax consequences arise from reimbursement of these expenses, I am responsible for payment of such taxes. I also understand that my plan sponsor may have access to a summary of the total amounts claimed by me under my Health Spending Account for the purposes of tax or administrative reporting.

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 (d/m/y)
X	

Respecting your privacy

Your privacy is important to us. We may leverage our strengths in our worldwide operations and in our negotiated relationships with third party providers to help us service some of our customers. In some instances our employees, service providers, agents, reinsurers and any of their service providers, may be located in jurisdictions outside Canada, and your personal information may be subject to the laws of those foreign jurisdictions.

Questions? Please visit **www.sunlife.ca** or call 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 6076 Stn CV
Montreal QC H3C 4S3

Sun Life Assurance Company of Canada
PO Box 3417 Stn D
Ottawa ON K1P 1G1

Sun Life Assurance Company of Canada
PO Box 2880 Stn Main
Edmonton AB T5J 4S6

We will issue an Explanation of Benefits which should be kept for your records.