Claim authorization form

Sun Life Financial

Clear

Member information

Name of University/College/School Board		Policy number	Member ID
Member's last name	Member's first name		
Member's telephone number	Member's email address		
Canadian address (street number and name)		Apartment or suite	
City		Province	Postal code
Healthcare provider or name of clinic			

Spouse and/or dependents covered by the member's coverage

First name	Last name

Authorization and signature

I authorize the healthcare provider/clinic named above to submit claims on my behalf to Sun Life Assurance Company of Canada (Sun Life).

I agree that Sun Life can make payments directly to the Provider. I understand that payment by Sun Life to the Provider discharges Sun Life's payment obligation to pay me. Sun Life may pay me directly for claims despite this signed Claim Authorization Form and that any payment to me instead of the Provider discharges Sun Life's payment obligation.

I authorize Sun Life, its agents and services providers and as applicable the plan administrators to collect, use and exchange information needed for underwriting, administration, adjudicating claims and claims management under this insurance coverage. This information can be shared with any person or organization who has relevant information about me including health professionals, government agencies, provincial health care plan, institutions, investigative agencies insurers, reinsurers and, as applicable, the plan sponsor and plan administrator. I understand that for audits and administrative reporting, the plan sponsor or administrator of this insurance coverage may have access to statistical and financial information without person identifiers.

If there is suspicion of fraud and/or abuse related to my claim, I understand and agree that Sun Life, its agents and service providers may exchange information about my claim for the purpose of investigation and prevention of fraud and/or abuse with any relevant organization, including as applicable the plan sponsor and plan administrator, law enforcement bodies, regulatory bodies, government organizations and other insurers.

If there is an overpayment, I authorize the recovery of the full amount of the overpayment from any amount payable to me.

If I am submitting claims for my spouse and/or dependents, I confirm that I am authorized by them to disclose personal information about them for the purposes described above to Sun Life, its agents and services providers and any person or organization who has relevant information about them including health professionals, government agencies, provincial health care plan, institutions, investigative agencies insurers, reinsurers and, as applicable, the plan sponsor and plan administrator.

I agree that a photocopy or electronic version of this authorization is as valid as the original. This authorization shall continue to have effect until revoked by me. I understand that this form will be kept on file by the Healthcare Provider or Clinic.

Member signature	Date (dd-mm-yyyy)
X	