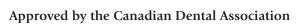
Dental & Health Spending Account Claim Form







1	То	be	complete	ed by	Dentist															
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Yo	ır addr	ess (s	treet number ar	nd name)			A	Apartment or s	uite	City					P	rovince	P	ostal code		
3	Sp	ou	se and chi	ldren	covered l	y this	clai	i m – comp	lete	this se	ction if cla	im is	for spo	use o	r child					
Spouse's last name Fi							First	t name					Date of			f birth (yy)	birth (yyyy-mm-dd)		☐ Male ☐ Female	
							ationship to yo		Date of birth (yyyy-mm-dd)			1 .	for age limits)			ependents (refer to benefit information sabled Full-time student				
1	Co	-01	dination	of bor	ofits so	mplata th	ic co	action if you	1K CK	ouco a	ad /ar chil	dran	has sov	orago	under	any oth	or dor	tal plan	or contract	
f y	our sp es,:	ous • Y • Y	e or are your ou must sub ou must sub e's plan is als	children mit a cla mit a cla	n covered for aim for your aim for your	any of the spouse to child firs	hese his t und	expenses ur /her plan fir der the plan	ndei rst.	r any ot	her dental	plan	or conti	ract?	□N	o 🗆 .	Yes			
Contract number Member ID number						Spouse's date of birth (yyyy-mm-dd) Do you want us to co-ordin No Yes						ordinate b	nate benefits (process both claims)?							
If yes, spouse's signature X														Date (yyyy-mm-dd)						
sir ece	ou're ig you ipts. I You d	cove ir Ha Pleas on' i	red under me SA to claim for se select one of twant to use us to assess t	ore thar or the un of the fo your HS	n one benefit npaid amour ollowing: SA for this cl	s plan, yo nt previou aim	ou sh isly s	nould consic submitted to	der s	submitt is or and You war	ing your cl other plan, nt us to ass	aim t , attao	to the ot the cl	her p laim s	lan(s) tateme er your	before u nt you r HSA or	eceive 1 ly .	d and a c	If you are opy of the	
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DENT-HSA-E-07-14

6 Details of claim If the cost of your treatment will exceed the pre-determination limit in your benefit plan, you should send an estimate to Sun Life Assurance Company of Canada. To determine if you will be reimbursed for the treatment, have your dentist complete a Pre-Treatment Form (available from your dentist). 1. Are any expenses the result of an accident? \square No \square Yes If yes, complete the following: Where did the accident occur? How did the accident occur? When did the accident occur? (yyyy-mm-dd) ☐ Work ☐ Home ☐ Other Are any expenses the result of a condition covered by a workers' compensation program? ☐ No ☐ Yes 2. Is this treatment for orthodontic purposes? \square No \square Yes ☐ No ☐ Yes Implants? 3. Crowns, Bridges, Dentures Is this the initial placement? \(\sigma\) No ☐ Yes If No, date of prior placement (yyyy-mm-dd) Reason for replacement If Yes, date teeth were extracted (for denture or bridge) Please include the following to facilitate handling of your claim: • Pre-treatment x-rays (for crowns, bridges, veneers, inlays, onlays) • List of all missing teeth (for bridges only)

7 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 am making a claim under my Health Spending Account, I certify that these expenses qualify for reimbursement.

I also 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. 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 (yyyy-mm-dd)
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.

To find out about our Privacy Policy, visit our website at www.sunlife.ca, or to obtain information about our privacy practices, send a written request by email to privacyofficer@sunlife.com, or by mail to Privacy Officer, Sun Life Financial, 225 King St. West, Toronto, ON M5V 3C5.

Questions? Please visit www.sunlife.ca or call our toll-free number 1- 866-896-6976 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

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PO Box 11658 Stn CV Montreal QC H3C 6C1 PO Box 2010 Stn Waterloo Waterloo ON N2J 0A6

> For SLF use: DCF