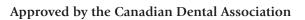
# **Dental Claim Form**







P A	Last Nar	Last Name Given Name					Unique Number   Spec.   Patient's Office Account				No.		I hereby assign my benefits payable from this claim to the named dentise and authorize payment directly to				
T	Address				Apt.	D E N								and author him/her.	ze payment dir	ectly to	
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Du	Duplicate Form							Signature of I							Patient (Parent/Guardian)		
								Office	Verification/De	ntist's S	ignature						
	of Service Month Year	Procedure Code	Intl Tooth Code	Tooth Surfaces		ntist's Fee	Labo Ch	oratory narge	Total Cha	rges	F	or Pla	an Ad	lminist	rator Use	e Only	
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You	Your address (street number and name)				Aparti	ment or sui	te C	City				Prov	ince	Postal code			
3	Spou	ıse and ch	ildren c	covered t	y this o	claim -	– comple	ete this	section if cla	aim is i	for spo	use or c	hild				
Spc	Spouse's last name					First nam	ie .					Date of bir			irth (yyyy-mm-dd)		
Ch:	Child's name					Relations	ship to you	D	Date of birth (yyyy-mm-d			for age limits)			pendents (refer to benefit information abled		
Cni						☐ Son	☐ Daugh		_			age limits	١		•	udent	
4	Co-o	ordination	of bene	efits – cor	nnlete th			ter	e and/or chil	_	for a		) _	Disabled	Full-time stu		
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#### 5 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: When did the accident occur? (yyyy-mm-dd) Where did the accident occur? How did the accident occur? ☐ Work ☐ Home ☐ Other ☐ No ☐ Yes Are any expenses the result of a condition covered by a workers' compensation program? 2. Is this treatment for orthodontic purposes? ☐ No Implants? $\square$ No ☐ Yes 3. Crowns, Bridges, Dentures Is this the initial placement? ☐ Yes If No, date of prior placement (yyyy-mm-dd) Reason for replacement If Yes, date teeth were extracted (for denture or bridge) (yyyy-mm-dd) 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)

### 6 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.

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 e-mail 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 toll-free 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 11658 Stn CV Montreal QC H3C 6C1

Sun Life Assurance Company of Canada PO Box 2010 Stn Waterloo Waterloo ON N2J 0A6

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