Assignment of Benefits to Health Care Provider

For an assignment of eligible expenses, please return this form to:

Sun Life Assurance Company of Canada
Health Claims Office
PO Box 6076 Stn CV
Montreal QC H3C 4S3

- Your Health Care Provider must agree to be paid directly by Sun Life Assurance Company of Canada before you submit this form.
- Attach the **original** claim form for all expenses subject to this assignment.

1 Information about you

Be sure to fully complete this section.

Contract Number	Your plan sponsor/employer	Member ID number
14098	York University	

Your last name	First name	☐ Male ☐ Female	Date of birth (dd/mm/yy)

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

Province	Postal code	You'd prefer correspondence in ☐ English ☐ French	Daytime phone number ( )

2 Assignment of Benefits to a Health Care Provider

This section must be completed in full by the Health Care Provider. Please remember to attach all itemized receipts.

Provider Information

Date of service (d/m/y)	Provider name	Practitioner's name

Address

City	Province	Postal Code

Signature or stamp of provider
X

3 Details of Claim for Health Care Provider

List the names of all persons for whom you're claiming expenses. Add up all the receipts and insert the total amount claimed.

Ensure each receipt clearly indicates the type of expense being claimed.

Person for whom you are making the claim	Date of birth (dd/mm/yy)	Relationship to you	Full-time student	Disabled	Amount claimed
Claimant (last name, first name)			☐ Yes ☐ No	☐ Yes ☐ No	$
			☐ Yes ☐ No	☐ Yes ☐ No	$
					Total Claimed $

4 Assignment of Benefits, Authorization and Signature

You must complete this section.

Assignment of Benefits

Benefits can only be assigned to providers approved by the Administrator of the Plan. For more details, please contact the Plan Administrator.

I hereby assign my benefits payable for the receipts attached to this claim form to the named Health Care Provider and in the event that my claim is approved, I authorize payment directly to them. I acknowledge and agree that any payment of benefits made in accordance with this assignment will validly discharge Sun Life Assurance Company of Canada of its obligations under the Plan. In the event that payment is made to me, Sun Life Assurance Company of Canada is also discharged of its obligations under the Plan, regardless of whether the benefit payment was subject to this Assignment.

In the event that my claim is declined under my plan sponsor's benefit plan, I agree that I remain responsible to pay the Health Care Provider for any services rendered.

I authorize Sun Life Assurance Company of Canada, its agents and service providers to use the information about me in this form for the purpose of processing any benefit payments under the plan.

This assignment shall apply to the claims submitted in the attached claim form only.

I agree that a photocopy or electronic version of this authorization shall be as valid as the original.

Member's signature	Date (yyyy/mmm/dd)
X	

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