Public Service Health Care Plan (PSHCP) Claim Form

- The PSHCP is administered by Sun Life Assurance Company of Canada, a member of the Sun Life Financial group of companies
- Mail the completed form to: Sun Life Assurance Company of Canada
  Health Claims Office, PO Box 9601 CSC-T, Ottawa ON K1G 6A1
  (613) 247-5100 or 1-888-757-7427 (toll-free)

Member Information

Contract Number **55555**	Certificate Number	Date of Birth Day / Month / Year
Last Name	Given Name	Language of Preference ☐ English ☐ Français
Street Address	Apt. Number	Daytime Tel. Number ( )
City / Province / Postal Code		Evening Tel. Number ( )

Are you covered for any of these expenses under any other medical plan as either an employee or pensioner? No ☐ Yes ☐ ▶ If yes, please indicate:

Name of Insurer: Contract Number: Certificate Number:

If you live in Canada, does this claim include expenses incurred outside your Home Province/Canada? No ☐ Yes ☐ ▶ If yes, please indicate:
Date of Departure: Were you on government business travel status? No ☐ Yes ☐

Complete if Spouse or Common-Law Partner Covered by this Claim

If common-law partner, has this relationship been in effect for at least one year? No ☐ Yes ☐

Full Name — Date of Birth Day / Month / Year

Is the above person covered for any of these expenses under another medical plan or contract other than the PSHCP? No ☐ Yes ☐ ▶ If yes, you must submit the claim to this person's plan first. If this person's plan is also with our Company, and you wish us to co-ordinate benefits, fill in the contract and certificate number below and attach a completed and signed claim form for the other plan.

Contract Number: Certificate Number:

Complete if Children Covered by this Claim

Name	Relationship to Member		Date of Birth			If child is 21 or over, check whether child is:	
	Son	Daughter	Day	Month	Year	Disabled	Full-time Student
	☐	☐				☐	☐
	☐	☐				☐	☐
	☐	☐				☐	☐

Are your children covered for any of these expenses under your spouse or common-law partner's medical plan or contract?
No ☐ Yes ☐ ▶ If yes, what is the month and day of this person's birthday? Month: Day:
Claim expenses for children under the plan of the parent with the earliest birthday (month and day) in the calendar year.

Details of Claim

Attach original receipts. If an expense has already been submitted under another plan, attach the original Explanation of Benefits from that plan AND copies of the receipts.

1. Are any expenses the result of an accident? No ☐ Yes ☐ ▶ If yes, complete the following:

When and where did the accident occur? Day / Month / Year — Work ☐ Home ☐ Other ☐

How did the accident occur?

Are any expenses the result of a condition covered by Workers' Compensation/Workplace Safety and Insurance Board? No ☐ Yes ☐

2. Fill in the total of all receipts for each category:

Prescription Drugs:	$
Other Medical Expenses: (Please specify eg. chiropractor, vision care, etc.)	$
Out-of-Province "Travel Benefit" Expenses:	$
TOTAL AMOUNT CLAIMED	$

Member Certification & Authorization

I certify that the statements in this claim are true and complete and do not contain a claim for any expenses 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 assessing and paying a benefit, if any. I authorize release of any information or record relating to this claim to Sun Life Assurance Company of Canada, or those performing services on our behalf, to be used for the limited and sole purposes of underwriting, administering and paying claims under the PSHCP. The Plan Administrator may check the accuracy of the information given in support of this claim.

Member Signature X — Date Day / Month / Year