

4 Co-ordination of benefits

Complete only if your Spouse and/or children has coverage under any other dental plan or contract.

Is your spouse and/or children covered for any of these expenses under any other dental plan or contract?	
No <input type="checkbox"/>	Yes <input checked="" type="checkbox"/> Spouse's date of birth (d/m/y): _____
If yes,:	
<ul style="list-style-type: none"> You must submit a claim for your spouse to his/her plan first. You must submit a claim for your child first under the plan of the parent with the earliest birthday (month and day) in the calendar year 	
If your spouse's plan is also with us:	Contract Number _____ Member ID: _____
Do you want us to co-ordinate benefits (process both claims)?	No <input type="checkbox"/> Yes <input checked="" type="checkbox"/>
If yes, Spouse's Signature: X	Date (d/m/y) _____

5 Health Spending Account

Your Health Spending Account can be used for eligible expenses that qualify for the medical expense tax credit under the Income Tax Act. This may include expenses not covered under your Dental Coverage or unpaid portion of dental care expenses that have been submitted to another plan.

Complete only if you are covered with a Health Spending Account.

Do you want any unpaid portion of this claim or other Dental Care expenses to be considered under your Health Spending Account?	No <input type="checkbox"/> Yes <input type="checkbox"/>
Note: If left blank, no portion of this claim will be considered under your Health Spending Account.	

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?	No <input type="checkbox"/> Yes <input checked="" type="checkbox"/>	If yes, complete the following:		
When and where did the accident occur (d/m/y): _____		Work <input type="checkbox"/>	Home <input type="checkbox"/>	Other <input type="checkbox"/>
How did the accident occur?				
Are any expenses the result of a condition covered by a workers' compensation program?		No <input type="checkbox"/> Yes <input type="checkbox"/>		
2. Is this treatment for orthodontic purposes?	No <input type="checkbox"/> Yes <input type="checkbox"/>	Implants?	No <input type="checkbox"/> Yes <input type="checkbox"/>	
3. Crowns, Bridges, Dentures	Is this the initial placement?	No <input type="checkbox"/> Yes <input type="checkbox"/>		
If No,	• Date of prior placement (d/m/y): _____	If Yes,	• Date teeth were extracted	
	• Reason for replacement: _____		(for denture or bridge (d/m/y): _____)	
Please include the following to facilitate handling of your claim:		<ul style="list-style-type: none"> Pre-treatment x-rays (for crowns, bridges, veneer, inlays, onlays) List of all missing teeth (for bridges only) 		

7 Authorization and Signature

You must complete this section.

Fraudulent claims are very costly for all participants in benefit plans. As Administrator of this plan, we may check the accuracy of the information given in support of your claim.

Note for Members: As part of the benefits payment and plan management process, we exchange information about claims with you, including claims for goods or services received by your spouse and dependents. This includes details such as the date of the claim, what the claim was for, and the amount of the claim. **Please ensure that your spouse and/or dependents are aware of, and consent to this process prior to submitting claims.**

For details specific to your plan, consult your benefit information package or visit our Web site,

www.sunlife.ca

I certify that all goods or services being claimed have been received by me, and if applicable, my spouse and/or dependents. 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.

I authorize Sun Life Assurance Company of Canada, its agents and service providers to use and exchange information about me, and if applicable, my spouse and/or dependents, needed for underwriting, administration and adjudicating claims under this Plan with any other person or organization who has relevant information pertaining to this claim including health professionals, institutions, investigative agencies, insurers and reinsurers. I understand that information pertaining to this claim may be reviewed in the event this Plan is audited.

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

I understand that expenses for which I am reimbursed under my Health Spending Account cannot be claimed for Income Tax purposes (except in Quebec where special rules apply). I also acknowledge that the persons for whom I am making a claim are eligible and include myself, my spouse and any dependents for whom I am eligible to claim a medical expense tax credit as defined in the Income Tax Act. 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.

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

Member's signature X	Date (d/m/y)
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Mail the completed form to the nearest Sun Life Assurance Company of Canada Health Claims office:

Sun Life Assurance Company
of Canada

PO Box 6076 Stn CV
Montreal QC H3C 4S3

Sun Life Assurance Company
of Canada

PO Box 3417 Stn D
Ottawa ON K1P 1G1

Sun Life Assurance Company
of Canada

PO Box 2880 Stn Main
Edmonton AB T5J 4S6

For more information call 1- 800-361-6212

Please retain a copy of your claim form and receipts for your records.