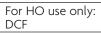
Dental Claim Form



Approved by the Canadian Dental Association

1	T	o b	e complete	ed by D	entist												
P A	Last Name				Given Name			ue Number	Spe	c. Patient's Off		ce Account No.			from this	issign my benefit claim to the nam	named dentist
T I	Ad	Address Apt.											and auth him⁄her.	orize payment dir	rectly to		
E N T	Cit	ty	I	Prov.	Posta	Code		Dhama Nia i								in the state	
	Dere	N. N. 1	In Only Frank					T Phone No.: dures, or I understand that the fees listed in this claim may no							Signature of Subscriber		
For Dentist's Use Only - For additional information, diagnosis, procedures, o special consideration.									benefi I ackno service	ts. I understa owledge that	and that the tot I authori	I am financi al fee of \$ ize release c	ally res	ponsible is	to my dentis accurate and	t for the entire ti has been charge n form to my ins	reatment. ed to me for
Duplicate Form Signature of Patient (Parent/Guardian))					
								Office Verification/Dentist's Signature									
	e of Sei		Procedure Code	Intl Tooth	Tooth Surfaces			's Laborat Charg		ry Total Charges		For F	lan <i>i</i>	Adminis	trator Use	e Only	
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Co	ntract	t numl	ber	Member I	D number	١	rour plan sp	onsor/emp	oloyer						Preferred	anguage of corre	spondence
															🗌 English	French	
Yo	ur last	t name	2			First nan	ne				1	Male	Date	of birth	(yyyy-mm-d	I) Daytime pho	ne number
											Female	emale — —					
Your address (street number and name)						Aparte	ment or suit		City P			rovince	ovince Postal code				
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Spouse's last name						First nam	e		Date o			Date o	f birth (yyyy-mm-dd) 🛛 Male		MaleFemale		
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Cn	nasn	ame						hip to you		for			Complete for overage dependents (refer to benefit information or age limits)				
								on 🗌 Daughter 👘 👘							Disabled	Disabled 🗌 Full-time student	
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16			calendar yeai			1	fall - '	-									
<u> </u>		<u>^</u>	use's plan is		-		e tollowi					1-				<u> </u>	
Contract number Member ID number					Spouse's o	date of	te of birth (yyyy-mm-dd)			Do you want us to co-ordinate be			enefits (process both claims)?				
						— — — □ No □ Yes				Yes							
L		If yes, spouse's signature						I					Date (yyyy-mm-dd)				
lf y	es, sp	ouse's	signature												D	ite (yyyy-mm-dd)
If y	ves, sp	ouse's	signature													ite (yyyy-mm-dd)





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 a	accident? 🗆 No 🗆 Yes If y	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								
Are any expenses the result of a condition covered by a workers' compensation program? 🗌 No 🗌 Yes									
2. Is this treatment for orthodontic purposes? \Box No \Box Yes Implants? \Box No \Box Yes									
3. Crowns, Bridges, Dentures Is this the initial placement? \Box No \Box 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 facili	ē ,	Pre-treatment x-rays (for crowns, bridges, veneers, inlays, onlays) List of all missing teeth (for bridges only)							
	•	LIST OF ALL HUSSING LECTI FIOL							

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 thirdparty 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