OMA Encore65 Accidental Fracture claim form

Sun Life Assurance Company of Canada, a member of the Sun Life Financial group of companies.

- Use this form to submit claims for the Fracture benefit for OMA Encore65
- Please print clearly
- Complete section A and have your physician complete section B. Sign both sections A and B
- Please note you are responsible for the cost of completing this form

Section A – Member statement

1 Member information

Policy number	Member ID number	☐ Male ☐ Female	Date of birth (dd-mm-yyyy)
17891			

Last name	First name

Address (street number and name)	Apartment or suite

City	Province	Postal code	Telephone number

2 Fracture information

Bone fractured (list all)
Date of injury (dd-mm-yyyy)

Health care professional last name	First name

Address (street number and name)	Apartment or suite

City	Province	Postal code

Name of hospital, clinic or health care facility attended	Admitted (dd-mm-yyyy)	Discharged (dd-mm-yyyy)

Provide a brief description of the accident that lead to the bone fracture

DC-3000

3 Declaration and authorization

You must also sign the Member's Authorization on the Physician's Statement.

I certify that the statements in this form are true and complete.

I understand that Sun Life Assurance Company of Canada ("Sun Life") may investigate my claim. I authorize Sun Life to collect, use and disclose information needed for underwriting, administration, adjudicating claims under this Plan to any person or organization who has relevant information about my claim including health professionals, institutions, investigative agencies, insurers and where applicable OMA Insurance. I understand that information about me pertaining to my claim may be reviewed in the event this Plan is audited.

I authorize Sun Life and OMA Insurance and their medical consultants to collect, use and disclose among them information about me except for details related to diagnosis, treatment or medication that is relevant to my claim for the purposes described above.

In the event there is suspicion of fraud and/or Plan abuse related to my claim, I acknowledge and agree that Sun Life may collect, use and disclose information about me pertaining to my claim to any relevant organization, which may include OMA Insurance, regulatory bodies, government organizations and other insurers, for the purpose of investigation and prevention of fraud 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 me to other persons or organizations, including credit agencies and where applicable OMA Insurance for that purpose.

I agree that my consent is valid for the duration of my claim, but for the purposes of audit, for the duration of the Plan. I agree that a photocopy of this authorization or electronic version is as valid as the original.

Any reference to Sun Life Assurance Company of Canada or OMA Insurance includes their respective agents and service providers. Any reference to medical consultants may include occupational health consultants or nurses.

Member's signature	Date (dd-mm-yyyy)
X	

4 Keeping your information confidential

At Sun Life Financial, protecting your privacy is a priority. We maintain a confidential file in our offices containing personal information about you and your contract(s) with us. Our files are kept for the purpose of providing you with insurance products or services that will help you meet your lifetime financial objectives. Access to your personal information is restricted to those employees, representatives and third party service providers who are responsible for the administration, processing and servicing of your contract(s) with us, or any other person whom you authorize. In some instances these persons may be located outside Canada, and your personal information may be subject to the laws of those foreign jurisdictions. You are entitled to consult the information contained in our file and, if applicable, to have it corrected by sending a written request to us.

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.

Mailing instructions – *keep the original copy of your claim form and receipts for your records*

To ensure prompt submission, please fax this form, along with any other information in support of your claim that you would like to submit, to the number that appears below. Please retain the original copy for your records. You do not need to mail information that you fax. If you are unable to fax this information, you can mail it to the address below.

If you have any questions, please contact *A&AClaims@sunlife.com*.

Sun Life Financial
PO Box 2002 Stn Waterloo
Waterloo ON N2J 0C1

Fax number: 1-855-233-9880

Section B – Physician's statement

1 Physician's statement

Important: Please enclose a copy of your patient's records, all test results and x-ray reports related to this fracture and applicable to this claim. The patient is responsible for the cost of completing this form.

Sun Life Assurance Company of Canada will pay a $50.00 administrative fee for a photocopy of your patient's records on receipt. (Please attach your invoice to this form.) If this amount is unreasonable due to the size of your patient's chart, please call 1-800-453-6207 to request pre-approval for an alternative fee.

Patient's last name	First name
Diagnosis	X-Ray taken? (Please attach report) ☐ Yes ☐ No
Cause of injury if known	
Were drugs or alcohol a factor? ☐ Yes ☐ No	
Please list level	

I certify the above section to be true, complete and to the best of my knowledge.

Physician's signature X			Date (dd-mm-yyyy)
Physician's last name (please print)	First name	Specialty	
Address (street number and name)			Apartment or suite
City		Province	Postal code

2 Patient's authorization

I authorize my doctor to collect, use and disclose my personal information to Sun Life Assurance Company of Canada, its agents and service providers, its reinsurers and their service providers for the purposes of underwriting, administration and adjudicating claims under this Plan. I agree that this authorization is valid throughout the duration of my claim or during the resolution of any decision relating to my claim that I have disputed, but for the purposes of audit, for the duration of the Plan. I agree that a photocopy of this authorization or electronic version is as valid as the original.

Member's signature X	Date (dd-mm-yyyy)