

OMA Encore65 Home Care Member 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 Home Care benefit for OMA Encore65
- Please print clearly
- Attach copies of all applicable clinical records, reports, and test results

1 Member information

Policy number 17890	Member ID number	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth (dd-mm-yyyy)	
Last name		First name		
Address (street number and name)				Apartment or suite
City	Province	Postal code	Telephone number	

2 Claim due to cognitive impairment

Name of test performed	Date of test (dd-mm-yyyy)	Test score		
Health care professional (name)				
Address (street number and name)				Apartment or suite
City	Province	Postal code	Telephone number	
Has the test been repeated?				Date (dd-mm-yyyy)
Provide brief description of the recommended treatment as a result of the test				

3 Claim due to frailty

Have you been assessed using a Frailty Scale? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of test	Date of test (dd-mm-yyyy)	Test score	
Name of assessor (or service if applicable)		Reference number	Telephone number	

How frequently do you need assistance with any of the following? Check all that apply

Money management <input type="checkbox"/> Often <input type="checkbox"/> Occasionally <input type="checkbox"/> Never	Shopping <input type="checkbox"/> Often <input type="checkbox"/> Occasionally <input type="checkbox"/> Never
Medication adherence <input type="checkbox"/> Often <input type="checkbox"/> Occasionally <input type="checkbox"/> Never	Housework <input type="checkbox"/> Often <input type="checkbox"/> Occasionally <input type="checkbox"/> Never
Food preparation <input type="checkbox"/> Often <input type="checkbox"/> Occasionally <input type="checkbox"/> Never	Getting around outside the house <input type="checkbox"/> Often <input type="checkbox"/> Occasionally <input type="checkbox"/> Never
Has your weight changed in the past year <input type="checkbox"/> Yes <input type="checkbox"/> No	Number of kgs Change %

DC-3000



3 Claim due to frailty (continued)

Have you had a timed Get Up and Go test in the past year <input type="checkbox"/> Yes <input type="checkbox"/> No	Date (dd-mm-yyyy)	Score
Have you been confined to a Long Term Care Facility <input type="checkbox"/> Yes <input type="checkbox"/> No	Date admitted (dd-mm-yyyy)	
Name of facility	Telephone number	

4 Declaration and authorization

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 X	Date (dd-mm-yyyy)
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5 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 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.

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