



## 4 Co - ordination of Benefits

Indicate 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: _____ / _____ / _____ Day Month Year
If yes:	
<ul style="list-style-type: none"> <li>You must submit a claim for your spouse to his/her plan first.</li> <li>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.</li> </ul>	
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: _____	Date: _____ / _____ / _____ Day Month Year

## 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 accident?		No <input type="checkbox"/> Yes <input checked="" type="checkbox"/>	If yes, complete the following:	
When and where did the accident occur?		Day / Month / Year	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: _____ / _____ / _____ Day Month Year	If Yes,	• Date teeth were extracted (for denture or bridge): _____ / _____ / _____ Day Month Year	
• Reason for replacement:				
Please include the following to facilitate handling of your claim:				
<ul style="list-style-type: none"> <li>Pre-treatment x-rays (for crowns, bridges, veneers, inlays, onlays)</li> <li>List of all missing teeth (for bridges only)</li> </ul>				

## 6 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.

I certify that all goods or services being claimed have been received by me/my dependents. 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 certify that the information in this form is true and complete and does not contain a claim for any expenses 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 needed for underwriting, administration and adjudicating claims under this Plan with any person or organization who has relevant information pertaining to this claim including health professionals, institutions, investigative agencies, insurers and reinsurers. I understand that information about me pertaining to this claim may be reviewed in the event that this Plan is audited.

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

Member Signature	Date	Day	Month	Year
		/	/	

For details specific to your plan, consult your benefit information package or visit our web site, [www.sunlife.ca](http://www.sunlife.ca)

Mail the completed form to the nearest Sun Life Assurance Company of Canada Health Claims Office:

### EASTERN REGION Atlantic Canada, Quebec and Eastern Ontario

PO Box 6076 Stn CV  
Montreal QC H3C 4S3  
1 800 361-2128

### CENTRAL REGION Ontario (except Eastern Ontario)

PO Box 4023 Stn A  
Toronto ON M5W 2P7  
(416) 753-4300  
1 800 361-6212

### WESTERN REGION Western Canada, N.W.T. and Yukon

PO Box 2880 Stn Main  
Edmonton AB T5J 4S6  
1 800 661-7334