Sun Life

EXTENDED HEALTH AND VISION CARE PLAN FOR UNIONIZED EMPLOYEES OF CP RAIL SYSTEM

Your benefits are paid for from a plan controlled by your employer. As part of audits or administrative reports, your employer may have access to pertinent personal information about you contained in your claims file. Fraudulent claims are very costly for employers and 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.

INSTRUCTIONS FOR THE USE OF THIS FORM

1. Employee's statement must be completed and signed by the employee.
2. Submit only original receipts and retain copies for your records; photocopies are not acceptable.
3. Receipts will not be returned. Your explanation of benefits statement is sufficient for income tax purposes.
4. Group your receipts by family members. Please make sure your receipt contains the following details otherwise your claim may be delayed:—

Name of patient
Date of purchase
Nature of medical supply or treatment
Amount charged
Name of prescribing physician

For prescribed drugs:
a) names of drugs
b) prescription numbers

For physiotherapy and nursing:
a) the professional degree of the party giving the service and relationship, if any, to the patient, and
b) a statement from the prescribing physician confirming such service was medically necessary and for what period.

RECEIPTS FOR AUTHORIZED PSYCHOLOGISTS' EXPENSES MUST INDICATE THE MEDICAL NECESSITY OF THE THERAPY.

5. Hold your expenses until they represent a significant amount (in excess of $50.00).
6. Regardless of the amount, expenses must be received no later than March 31 after the year in which they were incurred.

EMPLOYEE'S STATEMENT (COMPLETE IN FULL TO AVOID DELAY OF PAYMENT)

Contract No. 25040 | P.I.N. or Employee No. | Sex: ☐ Male ☐ Female

name | surname | Date of birth day month year 19

Address number & street | apartment

city | province | postal code

Is this claim for services required as the result of an accident? ☐ Yes ☐ No How did it happen? | Date of accident day month year

If dental accident, we require X-rays taken after the accident and prior to treatment (if any). | Where did it happen? ☐ at home ☐ at work ☐ elsewhere

Is spouse covered for any of these expenses under any medical plan or contract (including any insurance prepayment, service type, government plan or Workers' Compensation)? ☐ Yes ☐ No ☐ Not applicable - If yes: Name of spouse _____, Date of birth of Spouse _____,

Name of Employer_____ and Name of Group Medical Carrier _____.

N.B. Claims for spouse must first be submitted under the relevant plan or contract then to Sun Life, along with a copy of the settlement from the spouse's plan. Children must claim under the plan of parent with the earlier day and month of birth in the calendar year.

COMPLETE THIS SECTION ONLY IF CLAIM IS FOR A DEPENDENT

dependent name	relationship: spouse	son	daughter	date of birth: day	month	year	if dep. child is over 21: full time student	handicapped
1	☐	☐	☐			19	☐	☐
2	☐	☐	☐			19	☐	☐
3	☐	☐	☐			19	☐	☐
4	☐	☐	☐			19	☐	☐

If this claim includes expenses for a child over age 21, who is a student, please give the name of the educational institution in question:

EXAMINING PHYSICIAN OR OPTOMETRIST

Name of patient

Visual impairment : What was vision at latest observation — 1. with glasses, 2. without glasses | O.D. | O.S.

Does patient require a prescription change at this time?

Lenses? ☐ yes ☐ no Frames? ☐ yes ☐ no

New prescription | O.D. • | O.S. •

I hereby certify that the above information is accurate.

Name of Physician / Optometrist | Phone No. (Area Code) ( )

Physician or Optometrist's Signature _____

Date_____

I certify that the statements herein and attached are complete and represent no duplication of charges previously submitted. I authorize the following to exchange information needed for underwriting, administering or paying any claim: Sun Life of Canada, my employer, any person or organization who has relevant personal information about me including medical practitioners and institutions, or investigation agencies, insurers, and persons performing services for Sun Life.

Date ..... 19 ..... EMPLOYEE'S SIGNATURE .....

WHERE TO CLAIM—Mail the completed form directly to the Sun Life office in the province in which you reside.

NFLD./P.E.I./N.S./N.B./QUEBEC
Health Insurance
Claims Office
PO Box 6076 Stn CV
Montreal QC H3C 4S3

ONTARIO
Health Insurance
Claims Office
PO Box 4023 Stn A
Toronto ON M5W 2P7

MAN./SASK./B.C./ALTA/YUK./N.W.T.
Health Insurance
Claims Office
PO Box 2880 Stn Main
Edmonton AB T5J 4S6

ALL INFORMATION RECORDED ON THIS FORM IS CONFIDENTIAL