Sun Life Assurance Company of Canada

Accident Insurance Claim Statement

Instructions

☐ Send in ALL signed statements, which we require to properly review the claim. **Failure to provide complete and accurate information could result in the need for additional claims investigation, which could delay the initial benefit payment.**

- Employee Statement
- Attending Physician Statement
- Authorization Statement

☐ Prefill Section 1 on the Employee and Physician Statements.

☐ Physician must completely fill out and sign the Physician Statement or you may submit your hospital bill, medical EOB, or other evidence that supports a claimable event.

☐ Have all treating physicians keep a copy of your signed authorization for their files.

To file an Accident claim, mail this form to:

Sun Life Assurance Company of Canada
Accident Insurance Claims
P.O. Box 81915
Wellesley Hills, MA 02481

- OR **Fax to: 781-304-5599**

Employee statement

Group policy number

Who is this claim for?	☐ Employee	☐ Spouse	☐ Child

1 Employee information

Name of employee (first, middle initial, last)	☐ M ☐ F	Social Security number	Date of birth (mm/dd/yyyy)
Employee street address	City	State	Zip code
Home phone number:	Work phone number:	Cell phone number:	
Preferred form of contact	☐ Home phone	☐ Work phone	☐ Cell ☐ Mail
Name of employer (parent company name)			

2 Patient information (if not the employee)

Name of patient (first, middle initial, last)	☐ M ☐ F	Social Security number	Date of birth (mm/dd/yyyy)
Patient street address	City	State	Zip code

3 Information about the accident

Date of accident (mm/dd/yyyy)	Describe the accident

Did you go to hospital/ urgent care / walk-in clinic? ..... ☐ Yes ☐ No

If yes, name of the facility : _____

Phone: Admission date (mm/dd/yyyy): Discharge date (mm/dd/yyyy):

Did you get treated by a physician as a result of this accident? ..... ☐ Yes ☐ No

If "yes," please provide the contact information for your treating physician.

Name of treating physician	Specialty	Hospital phone

Street address	City	State	Zip code

Select the type of condition and provide details. More information may be required by your physician.

Is this a work-related injury? ..... ☐ Yes ☐ No

Have you missed work as a result of this injury/accident? ..... ☐ Yes ☐ No

4 Signature

I certify that the above statements are true and complete. I have read or had read to me the fraud warning for my state.

Employee's signature X	Date signed (mm/dd/yyyy)

If claimant is a minor, the employee should sign.

Claimant's signature X	Date signed (mm/dd/yyyy)

Sun Life Assurance Company of Canada

Accident Insurance Claim Statement

Claim submission options:

1) Submit your hospital bill, medical EOB, or other evidence that supports a claimable event; or
2) Have your physician complete this section

Attending Physician statement

Group policy number

1 Patient information

Patient is responsible for any costs associated with the completion of this form.

Name of patient (first, middle initial, last)		☐ M ☐ F
Social Security number	Date of birth (mm/dd/yyyy)	Patients phone number

2 Physician information

Complete all sections. Any missing information may result in a delay to your patient's claim. Be sure to print clearly and fax this form to 781-304-5599 or as instructed by your patient.

Name of attending physician (first, middle initial, last)	Specialty	Tax ID#

Street address	City	State	Zip code

Phone number	Fax number

Date of Service	Diagnosis Code ICD	Diagnosis Description	Procedure Code	Procedure Description

3 Physician's disability information

Has patient missed work as a result of this injury/accident? ..... ☐ Yes ☐ No

First date of total disability (mm/dd/yyyy)	Return to work date (mm/dd/yyyy)

4 Certification and signature

I certify that the above statements are true and complete. I have read or had read to me the fraud warning for my state.

Attending physician signature (original signature is required)	Date signed (mm/dd/yyyy)
X	

Fraud warnings

General fraud warning: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

AK: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

AL: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

AR, LA, MA, MN, NM, RI, TX and WV: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

AZ: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

CA: For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

CO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

DC: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

DE, ID and IN: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

FL: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

KS: Any person who knowingly and with intent to defraud any insurance company or other person files an Application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may be guilty of insurance fraud as determined by a court of law.

KY: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Fraud warnings, continued

MD: Any person who knowingly OR willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly OR willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

ME: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

NH: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

NJ: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

OH: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

OK: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

OR and VA: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

PR: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

TN and WA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

VT: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Sun Life Assurance Company of Canada

Accident Insurance Claim Statement

Authorization for Release and Disclosure of Health Related Information

This Authorization complies with the HIPAA Privacy Rule.

It is important for you to read, sign and submit all Authorizations in this packet. Failure to submit all Authorizations could result in a delay during the claims process.

I HEREBY AUTHORIZE any physician, health care provider, health plan, medical professional, hospital, clinic, laboratory, pharmacy benefit manager, or other medical or health care facility that has provided payment, treatment, or services to me or on my behalf to disclose my entire medical record and any other protected health information concerning me to the Claims Department of Sun Life Assurance Company of Canada ("the Company"), its subsidiaries, affiliates, third party administrators, and reinsurers.

I understand that such information may include records relating to my physical or mental condition, such as diagnostic tests, physical examination notes, and treatment histories, which may include information regarding the diagnosis and treatment of human immunodeficiency virus (HIV) infection, sexually transmitted diseases, mental illness, and the use of alcohol, drugs, and tobacco, but shall not include psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization, and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

I understand that The Company will use the information it obtains to: (a) underwrite my application for coverage; (b) make eligibility, risk rating, policy issuance and enrollment determinations; (c) obtain reinsurance; (d) administer claims and determine or fulfill responsibility for coverage and provision of benefits; (e) administer coverage; and/or (f) conduct other legally permissible activities that relate to any coverage I have or have applied for with The Company.

I understand that the Company will not disclose information it obtains about me except as authorized by this authorization; as may be required or permitted by law; or as I may further authorize. I understand that if information is re-disclosed as permitted by this authorization, it may no longer be protected by applicable federal privacy law.

I understand that: (a) this Authorization shall be valid no longer than the term of coverage under the policy; (b) I may revoke it at any time by providing written notice to Sun Life Financial, Group Accident Insurance Claims, One Sun Life Executive Park, Wellesley Hills, Massachusetts, 02481, subject to the rights of any person who acted in reliance on it prior to receiving notice of its revocation; and (c) my authorized representative and I are entitled to receive a copy of the authorization upon request.

A copy of this authorization shall be as valid as the original.

Print name of claimant or representative of claimant	Group policy number
If representative, description of your authority or relationship to claimant	
Signature of claimant or representative **X**	Date (mm/dd/yyyy)

Sun Life Assurance Company of Canada
Wellesley Hills, MA 02481
(800) 247-6875

PRIVACY INFORMATION NOTICE

This notice explains why Sun Life Assurance Company of Canada ("the Company") collects personal information about you, how we use that information, and under what circumstances we disclose it to others.

COLLECTION OF INFORMATION

We need to obtain information about you to determine whether we can provide the insurance benefits you have requested. As part of the claims process, we may ask you to undergo a physical examination, submit a statement from your physician, or provide copies of medical tests or other information relating to your health, finances, and activities.

We also may collect information about you from other sources. By signing the authorization for release and disclosure of health-related information and/or the authorization for release and disclosure of psychotherapy notes, you authorize us to obtain medical information about you that we need to underwrite your application. Depending on your particular circumstances, we may collect additional information about you from the following sources:

- physicians, health care providers, medical professionals, hospitals, clinics, or other medical or health-care-related facilities
- other insurance companies you have applied to for insurance
- public records, such as Social Security and tax records

DISCLOSURE OF PERSONAL INFORMATION

When you sign the authorization for release and disclosure of health-related information and/or the authorization for release and disclosure of psychotherapy notes, you authorize us to disclose information we have about you:

- to our reinsurers and
- as required or permitted by law.

In the course of the claims process, we may need to disclose information about you to others. The law permits us to disclose such information, without obtaining authorization from you, to:

- companies that help us conduct our business or perform services on our behalf,
- your physician or treating medical professional, and
- comply with federal, state or local laws, respond to a subpoena or comply with an injury by a government agency or regulator.

ACCESS, CORRECTION, AND AMENDMENT OF PERSONAL INFORMATION

Upon written request to the Company, you can:

- obtain a copy of the personal recorded information we have about you in our files (a fee may be charged to cover the cost of providing a copy of such information),
- request that we correct, amend, or delete any recorded personal information about you in our possession, and
- file your own statement of facts if you believe that the recorded personal information we have about you is incorrect.

To take any of these actions, please contact us at the following address for further instructions.

Contact us

By mail
Sun Life Assurance Company of Canada
Accident Insurance Claims
P.O. Box 81915
Wellesley Hills, MA 02481

By fax
781-304-5599

www.sunlife.com/us

Customer Service **800-247-6875** M–F 8:00 a.m. – 8:00 p.m., ET