

Public Service Health Care Plan (PSHCP) Claim Form Out-of-Country Claims (Comprehensive Coverage)

The PSHCP is administered by Sun Life Assurance Company of Canada, a member of the Sun Life Financial group of companies

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Member Information

Contract Number 55555	Certificate Number	Date of Birth	Day	Month	Year
Last Name	Given Name	E-mail Address			
Address					Apt. Number
City	Province/State	Country	Postal/Zip Code		
Daytime Tel. Number (incl. Country Code) ()	Evening Tel. Number (incl. Country Code) ()	Date of employee Posting			
Are you covered for any of these expenses under any other medical plan as either an employee or pensioner?		No <input type="checkbox"/>	Yes <input type="checkbox"/>	If yes, please indicate:	
Name of Insurer:	Contract Number:	Certificate Number:			

Complete if Spouse or Common-Law Spouse Covered by this Claim

If common-law partner, has this relationship been in effect for at least one year? No Yes

Full Name	Date of Birth	Day	Month	Year
Is the above person covered for any of these expenses under another medical plan or contract other than the PSHCP?		No <input type="checkbox"/>	Yes <input type="checkbox"/>	If yes, you must submit the claim to this person's plan first.

Complete if Children Covered by this Claim

Name	Relationship to Member		Date of Birth			If child is 21 or over, check whether child is:	
	Son	Daughter	Day	Month	Year	Disabled	Full-time Student
	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>

Are your children covered for any of these expenses under your spouse or common-law partner's medical plan or contract?

No Yes If yes, what is the month and day of this person's birthday? Month: Day:

Claim expenses for children under the plan of the parent with the earliest birthday (month and day) in the calendar year.

Details of Claim Attach original receipts. If an expense has already been submitted under another plan, attach the original Explanation of Benefits from that plan AND copies of the receipts

1. Are the expenses the result of an accident? No Yes 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 Worker's Compensation/Workplace Safety and Insurance Board/Commission of Occupational Health and Safety? No <input type="checkbox"/> Yes <input type="checkbox"/>						

IMPORTANT: Si vous préférez votre correspondance en français, veuillez cocher ici

Out-of-Country Claims (Comprehensive Coverage)



2. Please also complete this section if you are living outside of Canada and have "Comprehensive Coverage" under the PSHCP. The Comprehensive component of the plan is administered by World Access Canada on behalf of Sun Life Assurance Company of Canada.

Part A - Prescription Drug Expenses

Patient Name	Prescription Drug Name	Date Purchased			Country	Type of Currency	Amount Charged
		DD	MM	YY			

Part B - Other Medical Expenses

Patient Name	Type of Expense	Name of Hospital or Practitioner	Date of Service			Country	Type of Currency	Amount Charged
			DD	MM	YY			

TOTAL AMOUNT CLAIMED (Part A & Part B)

IMPORTANT: Please indicate in which currency you would like us to issue your benefit cheque, if other than \$CDN:	
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Please attach original receipts for expenses and keep copies for your records. We will not return original receipts since you will receive an Explanation of Benefits for income tax purposes. Your bills or receipts should include the name of the patient, the nature of the treatment, the name of the medical product or prescription, the name of the prescribing physician, the date, and the amount charged in the currency that you used.

Attach a written statement from the referring doctor if you are claiming for certain medical services or expenses such as medical equipment, nursing services, speech therapy, etc. The referral statement should confirm why the services were medically necessary and how long the services were needed.

You do not have to submit a claim every time an expense occurs. Claims may be submitted at any time during a calendar year in which eligible expenses are incurred. Be sure to file your claim no later than six months from the end of the year in which you incurred your expenses, because the Administrator has no obligation to recognize claims received beyond that date.

Once both page 1 and 2 are fully completed, please mail the form and the original receipts to World Access Canada at the following address:

World Access Canada, Inc.
Public Service Health Care Plan
PO Box 880
Waterloo ON N2J 4C3
CANADA

Member Certification & Authorization

I certify that the statements in this claim are true and complete and do not contain a claim for any expenses previously paid for by this or any other plan. 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 authorize release of any information or record relating to this claim to Sun Life Assurance Company of Canada, or those performing services on our behalf, to be used for the limited and sole purposes of underwriting, administering and paying claims under the PSHCP. The Plan Administrator may check the accuracy of the information given in support of this claim.

Member Signature	Date	Day	Month	Year
X		/	/	