Sun Life

PUBLIC SERVICE HEALTH CARE PLAN CLAIM FORM PAGE 1

Out-of-Country Claims -- Comprehensive Coverage

Member Information

Contract Number 55555 | Certificate Number | Date of Birth Day / Month / Year

Last Name | Given Name

Street 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? No ☐ Yes ☐ ➡ If yes, please indicate:
as an employee ☐ or pensioner ☐ and complete the following: Insurance Co.: _____

Contract Number: | Certificate Number:

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

If common-law spouse, 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 ☐ Yes ☐ ➡ If yes, you should submit the claim to this person's plan first.

Complete if Children Covered by this Claim

Name	Relationship to Member: Son	Daughter	Date of Birth: Day	Month	Year	If child is 21 and over, check whether child is: Disabled	Full-time Student

Are your children covered for any of these expenses under your spouse or common-law spouse'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.

Are the expenses the result of an accident? No ☐ Yes ☐ ➡ If yes, complete the following:

Where did the accident occur? Work ☐ Home ☐ Other ☐ When did the accident occur? Day / Month / Year

Are any expenses the result of a condition covered by Worker's Compensation? No ☐ Yes ☐

☞ Please complete Page 2 on the reverse of this form. ➡

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