Employee Paid Supplemental Claim

Sun Life Financial®

Instructions:
The purpose of this form is for the submission of additional documents after an initial claim has been filed. Complete one form for each family member.

Complete all applicable sections including the authorization section. **Attach a copy of the itemized bill, medical records or any other documentation to support this claim for benefits**. Documentation must include the name of the provider of service, the type of service and the date of service. See policy for details of covered items and services.

Submit this form and the accompanying documentation to the address, fax number or e-mail address stated at the bottom of this form.

Employee Information

Insured Employee Name _____ Employer name _____ Employer Phone# _____

Policy# _____ Social Security Number _____ Phone# _____

Mailing Address _____ E-mail Address _____

Are you still employed with Policyholder? ☐ Yes ☐ No Last day worked _____

Please check the type of benefit you are claiming

☐ Accident policy Date of accident _____ Description of accident _____

☐ Cancer policy _____

☐ Critical Illness policy _____

Comments regarding this claim submission _____

Claimant Information

This claim is for: Name _____ ☐ Self ☐ Spouse ☐ Dependent

Claimant Date of Birth _____ Social Security Number _____

(If different from above)

Physician Information

Name _____ Phone _____ Fax _____

Address _____

Hospital Information

Name _____ Phone _____ Fax _____

Address _____

I authorize any provider of medical services, insurance company, consumer reporting agency, Social Security Administration, governmental agency, educational institution, law enforcement agency or employer having medical information with respect to any physical or mental condition, rehabilitation and other non-medical information of me to give to Union Security Insurance Company, or its representative, any and all such information. **I UNDERSTAND** the information obtained by use of this authorization will be used by Union Security Insurance Company to determine the eligibility for benefits. I know that a photographic copy of this authorization shall be as valid as the original. I agree this authorization shall be valid for the duration of the claim. This authorization is not governed by HIPAA, however, when necessary, I may be asked to execute a HIPAA authorization form, allowing Union Security Insurance Company to use and disclose protected health information.

If I receive a benefit greater than that which I should have been paid, I understand this insurance company has the right to recover such overpayments from me, including the rights to reduce or adjust future benefits, if any.

Signature of claimant _____ Date _____

Insurance products are underwritten by Union Security Insurance Company (Kansas City, MO) and administered by Sun Life Assurance Company of Canada (Wellesley Hills, MA) in all states except New York. In New York, insurance products are underwritten by Union Security Life Insurance Company of New York (Fayetteville, NY) and administered by Sun Life and Health Insurance Company (U.S.) (Lansing, MI).

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