

# Handicapped Child Coverage



Sun Life Assurance Company of Canada, a member of the Sun Life Financial group of companies is committed to keeping information concerning the contents of this form confidential.

## 1 To Be Completed By Employer

This form should be used for a member's handicapped child who exceeds the age of "Child" specified in the group contract.

Employer's Name	Policy No.	Section
Member's Name (last, first)		Member ID
Does member currently have dependent coverage? No <input type="checkbox"/> Yes <input type="checkbox"/>		If yes, dependent coverage became effective on: Date (d/m/y)
Coverage requested for dependent: <input type="checkbox"/> Extended Health Care Coverage <input type="checkbox"/> Dental Care Coverage		
Authorized Signature X	Telephone Number ( )	Date (d/m/y)

## 2 To Be Completed By Member

Handicapped Dependent's Name (first, last)	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (d/m/y)
Handicapped Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Legally separated <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Common-Law		Date Handicap Began (d/m/y)
Nature of Handicap		
Is your handicapped dependent living with you and wholly dependent on you for support?		

### Member's Authorization and Certification

I certify that I am legally authorized to provide this authorization and certification. I certify that the dependent identified on this form is handicapped and meets the definition of "Child" as outlined in my group insurance contract and employee booklet. The information I have given in this form is true and complete.

I authorize Sun Life Assurance Company of Canada, its agents and service providers to use and exchange information needed for underwriting, administration and adjudicating claims under this Plan, with the dependent's doctor, or any person or organization who has relevant information pertaining to this claim including health professionals, institutions, investigative agencies, insurers and reinsurers.

I agree that a photocopy or electronic version of this authorization shall be as valid as the original.

Member's Signature X	Date (d/y/m)
-------------------------	--------------

## 3 To Be Completed By Attending Physician

The member is responsible for obtaining this form and any charges for its completion, unless prohibited by law. Please return completed form to Sun Life Assurance Company of Canada.

Diagnosis of patient's present condition.
Handicapped features of this condition.
Type and frequency of medication/treatment prescribed.

**3 To Be Completed By Attending Physician (continued)**

Date patient became incapable of self-support. (d/m/y)	Expected date when patient will be able to enter the workforce or attend school. (d/m/y)	
Date last attended school (year) (d/m/y)	Level of education attained	
Prognosis of patient's present condition.		
Physician's Name (please print clearly)	Speciality	
Address (street number and name, apartment or suite)	Phone No. ( )	Postal Code
Physician's Signature X		Date (d/m/y)

**Mail the completed form to the nearest Sun Life Assurance Company of Canada Health Claims office:**

**Health and Dental  
Claims Services**  
PO Box 2880, Stn Main  
Edmonton Alta T5J 4S6

**Health and Dental  
Claims Services**  
PO Box 6076, Stn CV  
Montreal QC H3C 4S3

**Health and Dental  
Claims Services**  
PO Box 3417, Stn D  
Ottawa ON K1P 1G1

**Health and Dental  
Claims Services**  
PO Box 4023, Stn A  
Toronto ON M5W 2P7

**For more information call 1 800 361-6212**

**E-mail: [www.sunlife.ca/member](http://www.sunlife.ca/member) or [Can\\_GrpMedAndDen@sunlife.com](mailto:Can_GrpMedAndDen@sunlife.com)**