

## HOSPITAL INDEMNITY INSURANCE

# Your Hospital Indemnity benefits

## How to submit a claim



### How do I submit a Hospital Indemnity claim?

We have multiple ways for you to submit your claim:

1. Online at [www.sunlife.com/account](http://www.sunlife.com/account)
  - Log in to your Sun Life account or create one
  - Select 'submit a claim' and follow the steps
  - You will receive an email confirmation after you submit your claim. If you don't see it in your inbox, please check your spam folder.
2. Via email, fax or mail
  - Visit [www.sunlife.com/findaform](http://www.sunlife.com/findaform)
  - Choose 'Hospital Indemnity'
  - Complete and print the Hospital Indemnity form, including the authorizations. Also include a copy of the itemized hospital bill (form UB-04) from your medical provider and/or other supporting documentation for the claim.
  - Send in the form

**Email:** [SLFWorksiteclaims@disabilityrms.com](mailto:SLFWorksiteclaims@disabilityrms.com)

**Fax:** 866-376-9480

**Mail:** Sun Life  
300 Southborough Drive  
Suite 200  
South Portland, ME 04106

### What happens next?

Once we receive your completed claims information, a claims professional will evaluate your Hospital Indemnity claim. During the evaluation process, we may request additional information from your treatment providers and may also contact your employer for confirmation of your enrollment for this coverage.

To check the status of your claim, contact Supplemental Health Claims at 877-820-5306.

**All inquiries or follow-up questions can be directed to Supplemental Health Claims at 877-820-5306, Monday through Friday, from 8 a.m. to 5 p.m. ET.**

This is a limited benefit policy. It does NOT provide basic hospital, basic medical, or major medical insurance. It is not a Medicare Supplement policy. The certificate has exclusions, limitations, and benefit waiting periods for certain conditions that may affect any benefits payable. Benefits payable are subject to all terms and conditions of the certificate. The policy, certificate and any rider, if applicable, may not be available in all states and may vary based on state laws and regulations. This product is inappropriate for individuals who are eligible for Medicaid coverage.

Group Hospital Indemnity Insurance is underwritten by Sun Life Assurance Company of Canada (Wellesley Hills, MA) under Policy Form Series 15-GP-01, 20-HI-C-01, 12-GPPort-P-01, 20-HIPORT-C-01 in certain states. Not available for use in New York.

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HIFL-EE-9689-e (08/21)

### 1 Instructions

To avoid unnecessary delays, be sure all parts of the claim statement are completed according to the instructions, and DO NOT SEPARATE the pages. You will need to submit your claim using the mail, fax, and/or e-mail information found on the last page under the "Contact Us" section.

1. Complete Sections 3, 4a and 5 if filing for the insured
2. Complete Section 3, 4b or 4c and 5 if filing for a dependent
3. Sign and date the Authorization sections
4. Provide documentation
5. Complete the Direct Deposit form if you wish deposit of approved benefit(s) to a financial account. A check will be issued to the home address if the direct deposit option is not selected.

Attach an itemized hospital bill for each claim. Documentation can be obtained by requesting a copy of the hospital bill (UB04) from the healthcare provider.

- The medical documentation needs to include:
  - the diagnosis
  - date(s) of service
  - the type of service
  - the name of the provider of the service

Hospital Admission and Discharge documents may also include the requested information.

Note: Billing statements and medical EOBs may not contain all the necessary information to process the claim.

Wellness Screening Benefit: See policy for covered tests or procedures. If submitting a claim for this benefit use the Wellness Claim Statement (Form GCIFM-7261).

### 2 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, 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.

## 2 Fraud warnings, continued

**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.

**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.

**NM:** 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 civil fines and criminal 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:** Any person who, with intent to defraud or knowingly providing false information may be guilty of fraud and may be subject to civil or criminal penalties.

**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.

**RI:** 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.

**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.

**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.

**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.

### 3 General information

Policyholder/employer name		Policyholder number	Phone number	
Street address	City	State	Zip code	

### 4 Patient information

Claiming benefits for:  Insured  Spouse  Dependent child

#### 4a. Insured:

Insured employee name (As it appears on your Social Security card)		<input type="checkbox"/> Male <input type="checkbox"/> Female	
Marital status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			
Social Security number	Date of birth (mm/dd/yyyy)	Home phone number	Mobile phone number
E-mail address			
Street address	City	State	Zip code

Did injury result from employment?.....  Yes  No  Currently disputed

#### 4b. Spouse:

Spouse name (As it appears on your spouse's Social Security card)		<input type="checkbox"/> Male <input type="checkbox"/> Female	
Social Security number	Date of birth (mm/dd/yyyy)	Mobile phone number	

Did injury result from employment?.....  Yes  No  Currently disputed

#### 4c. Dependent:

See policy for the definition of a dependent. If over age 26, please provide proof of disability status.

Dependent name (As it appears on your dependent's Social Security card)		<input type="checkbox"/> Male <input type="checkbox"/> Female	
Social Security number	Date of birth (mm/dd/yyyy)	Mobile phone number	Married <input type="checkbox"/> Yes <input type="checkbox"/> No

Did injury result from employment?.....  Yes  No  Currently disputed

### 5 Claim information

The following benefits, subject to the election of your employer, may be covered under your Certificate. The benefit available and the amount payable for each covered benefit will be shown in the Certificate. See the Certificate for the definition of benefits.

In order for benefits to be processed, please provide documentation of the hospital admission. The itemized documentation must include the name of the provider, date(s) of service, type of service and charge.

The following checklist can assist in your submission. (Check all that apply.)

Type of service:

<input type="checkbox"/> Hospital admission – (non ICU setting)	<input type="checkbox"/> ICU (Intensive Care Unit admission)	<input type="checkbox"/> Rehabilitation Unit admission
<input type="checkbox"/> Emergency Room (accident only)	<input type="checkbox"/> Lodging	<input type="checkbox"/> Transportation
<input type="checkbox"/> Observation	<input type="checkbox"/> Inpatient Surgery	

## 5 Claim information, continued

Describe the type of claim:

<input type="checkbox"/>	Accident
<input type="checkbox"/>	Pregnancy
<input type="checkbox"/>	Sickness

Were services rendered at a facility owned by your employer? Yes  No

Name of hospital			
Street address	City	State	Zip code
Admission date (mm/dd/yyyy)		Discharge date (mm/dd/yyyy)	

Provide the following information of the primary care physician.

Name of physician	Specialty	Phone number	
Street address	City	State	Zip code

Provide the following information of any other referring physician(s) related to this claim.

Name of physician	Specialty	Phone number	
Street address	City	State	Zip code

Name of physician	Specialty	Phone number	
Street address	City	State	Zip code

## 6 Signature

If Power of Attorney, Guardian or Conservator, please attach a copy of the document granting that authority and sign below.

If I receive a benefit greater than that which I should have been paid, I understand that Sun Life Assurance Company of Canada has the right to recover such overpayments from me, including the rights to reduce or adjust future benefits, if any.


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)
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If claimant is a minor, the employee should sign.


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

 **By mail**  
Sun Life Assurance Company of Canada  
300 Southborough Drive, STE 200  
South Portland, ME 04106-6914

 **By fax**  
866.376.9480

**By e-mail**  
[sfworksitclaims@disabilityrms.com](mailto:sfworksitclaims@disabilityrms.com)

 [www.sunlife.com/us](http://www.sunlife.com/us)

 Customer Service **877-820-5306** M-F 8:00 a.m. – 5:00 p.m., ET

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## 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, healthcare provider, health plan, medical professional, hospital, clinic, laboratory, pharmacy benefit manager, medical information retrieval services, electronic health record company, health care information technology company, health information exchange, or other medical or healthcare facility that has provided payment, treatment or services to me or on my behalf to, or has medical or health related records or knowledge of me, 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, employees, agents, representatives, 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, healthcare professional, hospital, clinic, medical facility or other healthcare provider to release and disclose my entire medical record without restriction.

I understand that the Company may 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; (f) assist my employer in reviewing and evaluating requests for statutory leaves and/or accommodations as part of the interactive process under the Americans with Disabilities Act or other applicable laws; and/or (g) conduct other legally permissible activities that relate to any coverage I have or have applied for with the Company, including but not limited to any request for leave or workplace accommodation.

I authorize the Company to disclose information it obtains about me to the following persons to the extent necessary for the recipient to provide claim management or advisory services, to audit the administration of claims, or to verify, evaluate and/or adjudicate my claim: (a) the Company's subsidiaries and affiliates, (b) my employer, its agents, and any plan sponsor, administrator or other service provider of any benefit plan in which I participate or leave/accommodation services associated with my employment; (c) my treating physicians, psychologists and therapists/counselors; (d) other persons or organizations performing medical, investigative, financial or legal services related to my claim; (e) my insurer, if the Company is acting only as the administrator of my claim and; (f) other insurance companies, third party administrators or insurance support organizations to prevent fraud or material nondisclosure in connection with insurance transactions. 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 for 24 months from the date of signature; (b) I may revoke it at any time by providing written notice to Sun Life Assurance Company of Canada, 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 personal representative of claimant	Group policy number
If representative, description of your authority or relationship to claimant	Claimant date of birth (mm/dd/yyyy)
Signature of claimant or personal representative X	Date signed (mm/dd/yyyy)



## Authorization for Release and Disclosure of Non-Health Related Information

I HEREBY AUTHORIZE any: (a) physician, healthcare provider, health plan, medical professional, hospital, clinic, laboratory, therapist, pharmacy benefit manager, medical information retrieval services, electronic health record company, health care information technology company, health information exchange, or other medical or healthcare facility that has provided payment, treatment or services to me or on my behalf, or has medical or health related records of knowledge of me; (b) benefit plan administrator; (c) employer; (d) insurance company; (e) insurance support organization; (f) state department of motor vehicles; (g) consumer reporting agency; (h) financial institution; (i) government agency, or the Medical Information Bureau, Inc., Social Security Administration, Internal Revenue Service or the Veteran's Administration, to disclose to Sun Life Assurance Company of Canada ("the Company"), its subsidiaries, affiliates, employees, agents, representatives, third party administrators, and reinsurers, any and all non-health information relating to me, including, but not limited to (a) my employment earnings; (b) my occupational duties; (c) my credit history; (d) insurance benefits I may be receiving or have received; (e) Social Security benefits I, or my dependents, may be receiving or have received; (f) insurance claims I may have filed or insurance coverage I may have; (g) traffic accident reports relating to me; and (h) any other financial information relating to me.

I understand that the Company may 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; (f) assist my employer in reviewing and evaluating requests for statutory leaves and/or accommodations as part of the interactive process under the Americans with Disabilities Act or other applicable laws; and/or (g) conduct other legally permissible activities that relate to any coverage I have or have applied for with the Company, including but not limited to any request for leave or workplace accommodation.

I authorize the Company to disclose information it obtains about me to the following persons to the extent necessary for the recipient to provide claim management or advisory services, to audit the administration of claims, or to verify, evaluate and/or adjudicate my claim: (a) the Company's subsidiaries and affiliates; (b) my employer, its agents, and any plan sponsor, administrator or other service provider of any benefit plan in which I participate or leave/accommodation services associated with my employment; (c) my treating physicians, psychologists and therapists/counselors; (d) other persons or organizations performing medical, investigative, financial or legal services related to my claim; (e) my insurer, if the Company is acting only as the administrator of my claim and; (f) other insurance companies, third party administrators or insurance support organizations to prevent fraud or material nondisclosure in connection with insurance transactions. 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.

This Authorization shall apply to information relating to my dependents where applicable.

I understand that: (a) this Authorization shall be valid no longer than 24 months from the date of signature below; (b) I may revoke it at any time by providing written notice to Sun Life Assurance Company of Canada, 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 personal representative of claimant	Group policy number
If Representative, description of your authority or relationship to claimant	Claimant date of birth (mm/dd/yyyy)
Signature of claimant or personal representative X	Date signed (mm/dd/yyyy)