



Application Form



Sun Life Assurance Company of Canada is a member of the Sun Life Financial group of companies.

Policy numbers
Sun Life Assurance Company of Canada – 50150 American Home Assurance Company – SRG9114277

- Please check one of the following:**
- | | | |
|--|---|--|
| <input type="checkbox"/> Student and dependent application | <input type="checkbox"/> Employee and dependent application | <input type="checkbox"/> Post-doctoral fellow application |
| <input type="checkbox"/> Extension of coverage | <input type="checkbox"/> OHIP waiting period | <input type="checkbox"/> Dependent or late dependent application |
| <input type="checkbox"/> Change of information | | |

Your privacy is important to us. To view Sun Life Financial's privacy policy please refer to www.sunlife.ca or to the UHIP® booklet "University Health Insurance Plan (UHIP®) your basic health care solution" which can be found at www.uhip.ca.

Please PRINT clearly.

1 Personal information

Important note:
 Please advise Sun Life Financial or your UPA immediately of any changes in your status. This includes new address, phone number, addition of dependents, etc.)

University name		Member identification number	
Family name		First and middle names	
Date of birth (d/m/y)	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Coverage needed <input type="checkbox"/> One person <input type="checkbox"/> Two persons <input type="checkbox"/> Three or more persons	
Country of origin		Email address	
Canadian address (street number and name, apartment or suite)			
City	Province	Postal code	Telephone #
Member's effective date of coverage (d/m/y)	Number of months of coverage required	Dependent's effective date of coverage (d/m/y)	Number of months of coverage required

2 Dependent information

If you have or will have eligible dependents living with you in Canada, they **must** be covered by UHIP® or a recognized plan. Provide required information on additional dependents on an attached sheet.

Family name	First and middle names	Relationship		Sex		Date of birth		
		Spouse	Child	Male	Female	Day	Month	Year
		<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"/>			

I confirm that my common-law or same-sex relationship has existed for at least 12 months.

3 Request for waiver

Please attach a Request for UHIP® exemption form with your application.

I am covered under:

Name of plan

- I am covered under the above plan, but my dependents require coverage under UHIP®.
 I and my dependents are covered under the above plan.

If you are not covered under a recognized plan, you must first pay the full premium for UHIP® coverage, and then apply for an exemption. If the plan named above of which you are a member, is recognized, you may then apply for a refund of UHIP® premium.

Shaded area to be completed by university UHIP® plan administrator

Proof of coverage under a pre-approved plan reviewed

University UHIP® plan administrator's signature
 X

4 Authorization and signature

I declare that my answers in this application are true and complete and I understand that concealment, misrepresentation and false declaration concerning this application will cause the insurance to be void.

I authorize Sun Life Assurance Company of Canada and American Home Assurance Company (the insurers), their agents and service providers and the UHIP® plan administrator to use and exchange relevant information about me in connection with this application, for the purposes of underwriting, administration and adjudicating claims under this insurance coverage. The insurers are committed to keeping this information confidential.

I understand that UHIP® is compulsory and I am responsible for enrolling my dependents on my date of arrival. If, however, my dependents arrive at a later date, I must enrol them within 30 days of their date of arrival in Canada. Otherwise, I will have to pay a late application fee of \$500 and premiums retroactive to their date of arrival. I confirm that I am authorized to disclose information about my spouse and dependents in order to enrol them in this plan.

I further understand that the coverage I have indicated on this form will be assumed to hold true for the duration of my program of studies at the university, unless I communicate to Sun Life Assurance Company of Canada any change to my personal situation that would require adjustment of my premium (e.g. addition of dependents).

By signing below, I release the University from any responsibility for any undeclared dependents and for health care costs incurred by me or any of my dependents that are not eligible for reimbursement by UHIP® or a pre-approved plan. I understand that the University will accept no financial liability for any such costs.

A photocopy or electronic version of this authorization is as valid as the original and will remain in effect for the duration of my coverage under the UHIP® Plan.

Member's signature
 X

Date (d/m/y)

5 Temporary proof of coverage

Shaded area to be completed by university UHIP® plan administrator

Standard enrolment		
Effective date of coverage (d/m/y)	Coverage termination date (d/m/y)	Premium paid/owing \$
Expiry date of temporary proof of coverage (d/m/y)	Name of person issuing temporary proof of coverage	Signature of person issuing temporary proof of coverage X
Late entrant/dependent enrolment		
Date from which retroactive premium is due (d/m/y)	Late application fee of \$500 (dependent enrolment only)	\$500
Date validated (d/m/y)	Retroactive premium (premium rates in effect at time of application)	\$
University stamp		Premiums for remaining period of current academic year
<div style="border: 1px solid black; padding: 5px; width: fit-content;"> Form not valid unless stamped </div>		Total premium due
		\$

INQUIRIES Toll free: 1-866-500-UHIP (8447), Monday to Friday
 7h00 to 20h00 Eastern Standard Time
 E-mail: askus@sunlife.com

Please return your completed form to your university UHIP® Plan Administrator.