



How to complete the Claim Appeal Form

- ✓ Print clearly in pen, using block letters.
- ✓ Enter all dates numerically (4 numbers for year, 2 numbers each for month and day).
- ✓ Once completed, return the form to the UHIP®-UPA.

1. Date you are submitting the claim appeal.
2. Member identification number.
3. University name.
4. Full name of the person receiving the service: last, first, and middle (your name or that of a family member).
5. Claim number (this can be obtained from the Explanation of Benefits form).
6. Date the service was provided (make sure that you don't indicate the current date by mistake).
7. The reason given by the UHIP® insurer for the denial of your claim.
8. The reason you are appealing the decision.
9. Identify the expenses being appealed.
10. Your signature and your complete Canadian address, including postal code.



Claim Appeal Form



Instructions:
Please complete this form in full and return it to the University Plan Administrator.
Sun Life Assurance Company of Canada, a member of the Sun Life Financial group of companies, is committed to keeping your information confidential.
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 Appeal details

Date of appeal (d/m/y)		
1		
I hereby appeal denial of the following claim:		
Policy number		
Sun Life Assurance Company of Canada – 50150		American Home Assurance Company – SRG9114277
Member identification number	University name	
2	3	
Claimant name (first, middle, initial, last)	Claim number (see Explanation of Benefits form)	Date of service (d/m/y)
4	5	6
Reason for denial		
7		
Reason for appeal		
8		
Claim expenses being appealed		
9		

2 Authorization and signature

IMPORTANT:
You must sign and date the form.

I hereby agree to disclose to Sun Life Assurance Company of Canada and American Home Assurance Company (the insurers) the names and addresses of all health caregivers/practitioners who have provided treatment in connection with this claim within the last six months, for the purpose of making a further assessment of my claim. *Please attach list.*

Based on this disclosure, I hereby authorize any licensed physician, medical practitioner, hospital, clinic, medical facility or organization that has records of or information pertaining to the above claim to release such records or information to the insurers, for its consideration of my claim appeal. A photocopy of this signed appeal and authorization shall be as valid as the original and shall continue to have effect through the duration of this appeal.

I will be happy to provide any additional information that may be required for my claim appeal.

Member's signature	Date (d/m/y)
X 10	
Address (street number and name, apartment or suite)	
Telephone	E-mail address

SM-081-E-03-09