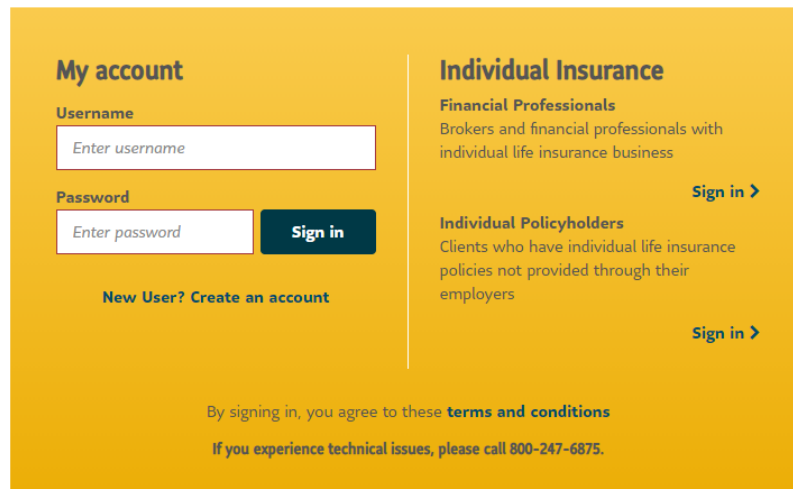


## How to submit an Accident, Cancer, Critical Illness or Hospital Indemnity claim online

### Step 1:

Sign in to your Sun Life member account – [www.sunlife.com/account](http://www.sunlife.com/account)

- You can sign in from a desktop, tablet or mobile device.
- If you don't have an account, you can create one at [www.sunlife.com/createaccount](http://www.sunlife.com/createaccount)



The screenshot shows the Sun Life Sign In page. On the left, under 'My account', there are input fields for 'Username' (with placeholder 'Enter username') and 'Password' (with placeholder 'Enter password'), followed by a 'Sign in' button. Below these is a link: 'New User? Create an account'. On the right, under 'Individual Insurance', there are two sections: 'Financial Professionals' (Brokers and financial professionals with individual life insurance business) with a 'Sign in >' link, and 'Individual Policyholders' (Clients who have individual life insurance policies not provided through their employers) with a 'Sign in >' link. At the bottom, there is a disclaimer: 'By signing in, you agree to these terms and conditions' and a support line: 'If you experience technical issues, please call 800-247-6875.'

### Evidence of Insurability / Submit a Claim

If you would like to provide evidence of insurability to apply for coverage, [click here](#).

If you would like to submit a claim, sign in or [create an account](#) to get started.

### Sign-in help

[I forgot my username](#)

[I forgot my password](#)

[My account is suspended](#)

If you encounter issues with our website, please follow the below instructions based on your browser type.

[Internet Explorer IE 11](#) [Mozilla Firefox](#) [Google Chrome](#)

### Common support questions

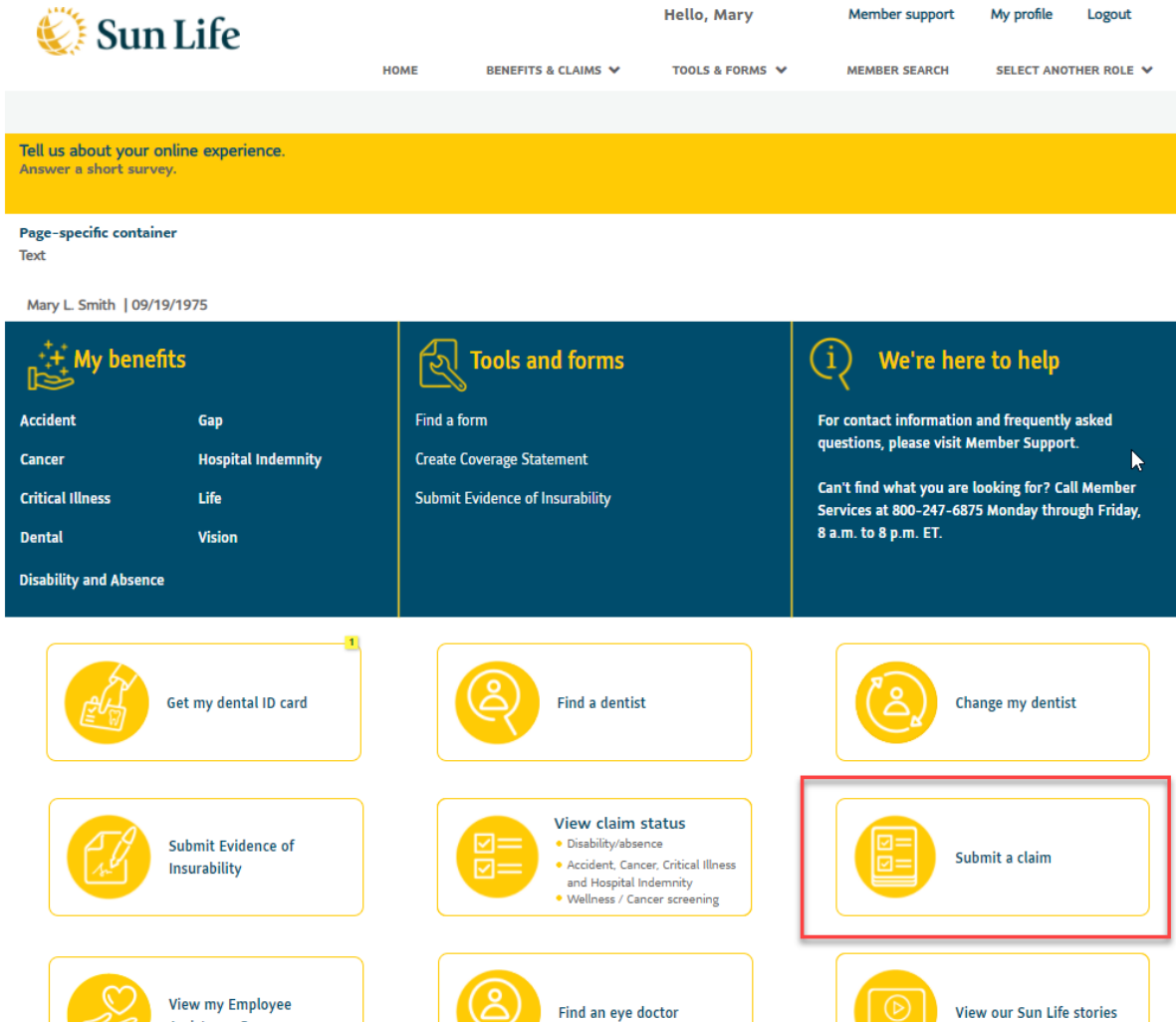
[How do I submit or track a claim?](#)

[Where can I find a form?](#)

[How do I find a dentist?](#)

**Step 2:**

From the member home page, select **“Submit a claim”**



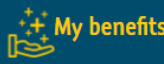
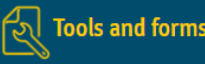
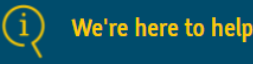
**Sun Life** Hello, Mary Member support My profile Logout










HOME BENEFITS & CLAIMS TOOLS & FORMS MEMBER SEARCH SELECT ANOTHER ROLE

Tell us about your online experience. Answer a short survey.

Page-specific container  
Text

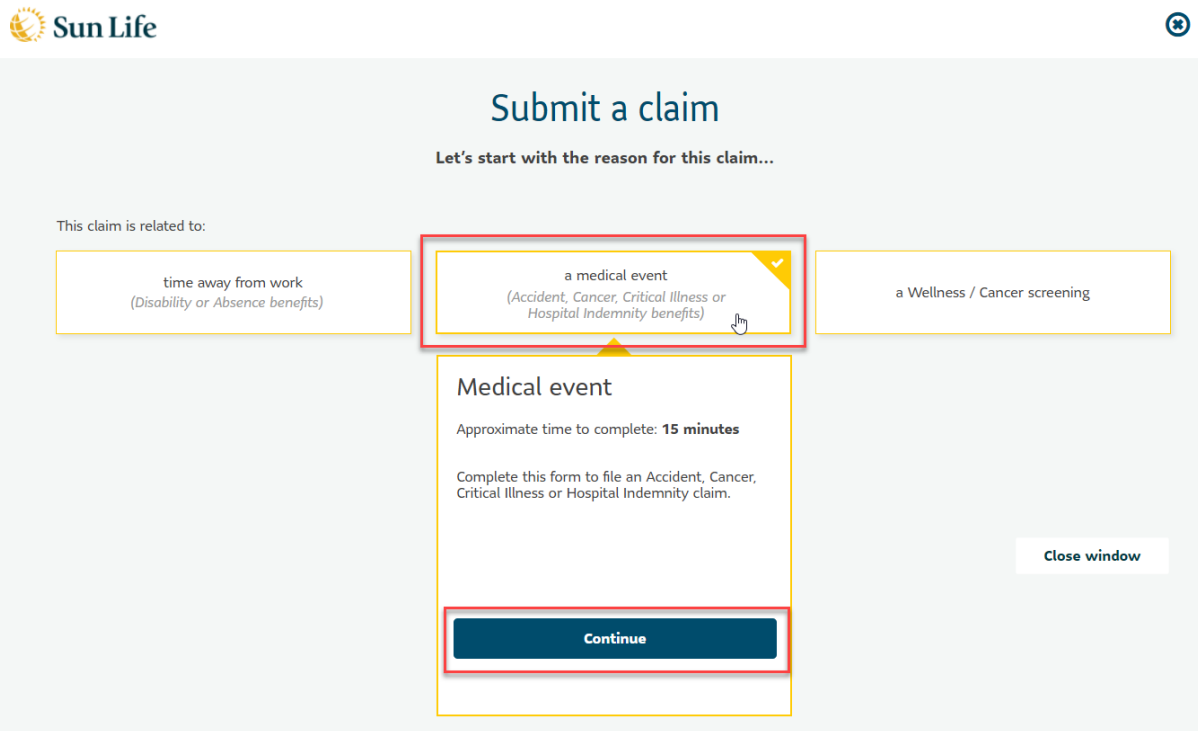
Mary L. Smith | 09/19/1975

 <b>My benefits</b> Accident Cancer Critical Illness Dental Disability and Absence Gap Hospital Indemnity Life Vision	 <b>Tools and forms</b> Find a form Create Coverage Statement Submit Evidence of Insurability	 <b>We're here to help</b> For contact information and frequently asked questions, please visit Member Support. Can't find what you are looking for? Call Member Services at 800-247-6875 Monday through Friday, 8 a.m. to 8 p.m. ET.
---	---	--

 Get my dental ID card	 Find a dentist	 Change my dentist
 Submit Evidence of Insurability	 <b>View claim status</b> <ul style="list-style-type: none"><li>Disability/absence</li><li>Accident, Cancer, Critical Illness and Hospital Indemnity</li><li>Wellness / Cancer screening</li></ul>	 <b>Submit a claim</b>
 View my Employee Assistance Program	 Find an eye doctor	 View our Sun Life stories

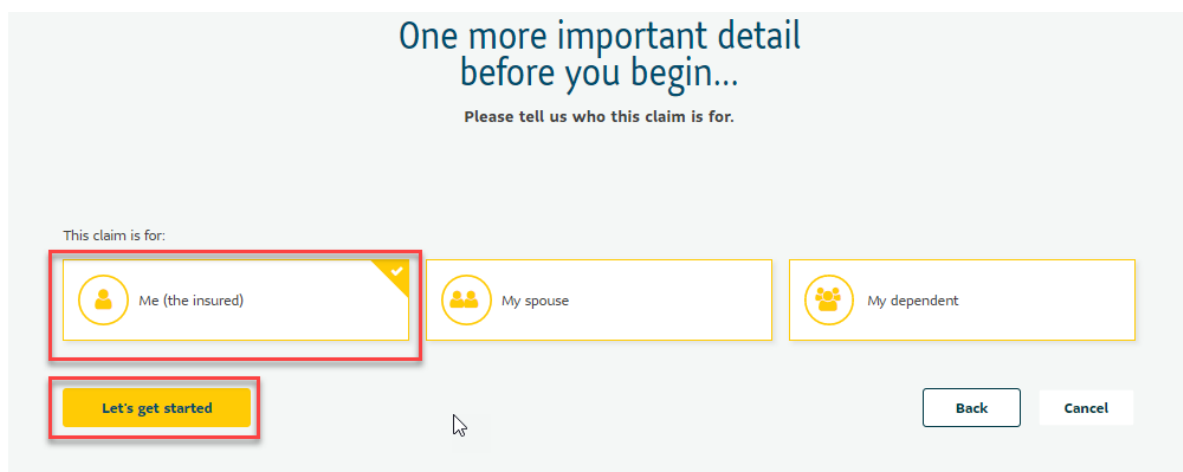
**Step 3:**

Select the box for a **medical event** and click **Continue**



**Step 4:**

Choose who this claim is for, and then click **Let's get started**



**Step 5:**

Enter the details for the Insured / Claimant and then click Continue


**1 Insured / Claimant information**

About you:

Your name  
Mary Spadaro

Your date of birth  
mm/dd/yyyy

Your Social Security number  
\*\*\*-\*\*-\*\*\*\*

Your assigned sex at birth   
 Female  Male

Your address  
Address line 1 Address line 2 (optional)  
City State ZIP code


Your phone number  
(123) 456-7890

Your email address Confirm your email address  
mary.spadaro@email.com mary.spadaro@email.com

About your dependent:

Dependent's name  
First name Last name

Dependent's date of birth  
mm/dd/yyyy

Dependent's assigned sex at birth   
 Female  Male

**Step 6:**

Next, provide us details of this claim, and upload any relevant documents to support this claim. Click **Continue** once you've entered all details.

**\*\*Note: the screens displayed in steps 6 & 7 will be different based on the product you are submitting a claim for. The examples below depict Accident submission only.**

2 **Claim details**

**Next tell us what happened and upload supporting documents.**

**Reminder**  
Supporting documents are required to process your claim. If the documents are not ready yet, you might consider canceling this claim and returning when they are ready.

**Documents for an Accident claim**

You will need to provide an itemized bill or medical insurance Explanation of Benefits (EOB) for each charge to be considered. Here are the types of documents we will need based on the services received.

If a **hospitalization** occurred:  
Copy of a hospital bill indicating diagnosis, services or treatment, and days hospitalized

If **surgery** was performed:  
Copy of the operative report

If a **motor vehicle accident** occurred:  
Copy of the police report

If an **incident investigated by law enforcement** occurred:  
Copy of the police report

If a **death** occurred:  
Certified copy of the death certificate

**Other supporting documents** which may be provided are:  
Copy of medical bills, physician records, ambulance charges, lodging and transportation expenses, and other appropriate documentation to support your claim for benefits

**Download supporting documents** 📄

Download documents which may support your claim benefits

About the accident:

Date of accident  
 📅

Describe the details of the accident  
  
0/500

Was the accident work related?  
 Yes  No  Currently being disputed

Are any of the following a contributing factor in the accident?  
 Attempting suicide, committing a felony, complication of treatment, intoxication, self-inflicted or use of drugs  
 Yes  No

What benefits are you filing this claim for? (select all that apply)

<input type="checkbox"/> Accident emergency treatment <span style="color: #ffc107;">📌</span>	<input type="checkbox"/> Hospital Intensive Care Unit confinement
<input type="checkbox"/> Accidental death	<input type="checkbox"/> Laceration
<input type="checkbox"/> Accidental death common carrier	<input type="checkbox"/> Loss of hearing, sight or speech
<input type="checkbox"/> Accidental dismemberment	<input type="checkbox"/> Medical device
<input type="checkbox"/> Accident follow-up care	<input type="checkbox"/> Outpatient visit
<input type="checkbox"/> Ambulance <span style="color: #ffc107;">📌</span>	<input type="checkbox"/> Paralysis
<input type="checkbox"/> Anesthesia	<input type="checkbox"/> Physical or occupational therapy
<input type="checkbox"/> Blood / plasma / platelet transfusion	<input type="checkbox"/> Physician follow-up treatment
<input type="checkbox"/> Brain injury	<input type="checkbox"/> Prescription drug
<input type="checkbox"/> Burn	<input type="checkbox"/> Prosthesis
<input type="checkbox"/> Catastrophic accident	<input type="checkbox"/> Rehabilitation Unit
<input type="checkbox"/> Coma	<input type="checkbox"/> Skin graft
<input type="checkbox"/> Concussion	<b>Surgery benefit</b>
<input type="checkbox"/> Diagnostic exam	<input type="checkbox"/> Debridement
<input type="checkbox"/> Dislocation	<input type="checkbox"/> Exploratory surgery
<input type="checkbox"/> Emergency dental	<input type="checkbox"/> Hernia repair
<input type="checkbox"/> Emergency room treatment <span style="color: #ffc107;">📌</span>	<input type="checkbox"/> Laparoscopic surgery
<input type="checkbox"/> Epidural pain management	<input type="checkbox"/> Miscellaneous surgery
<input type="checkbox"/> Eye injury	<input type="checkbox"/> Open surgery
<input type="checkbox"/> Family lodging	<input type="checkbox"/> Ruptured / herniated disc
<input type="checkbox"/> Fracture	<input type="checkbox"/> Tendon / ligament / rotator cuff
<input type="checkbox"/> Gunshot wound	<input type="checkbox"/> Torn knee cartilage
<input type="checkbox"/> Hospital admission <span style="color: #ffc107;">📌</span>	<input type="checkbox"/> Transportation
<input type="checkbox"/> Hospital confinement	<input type="checkbox"/> Urgent Care facility
<input type="checkbox"/> Hospital Intensive Care Unit admission	<input type="checkbox"/> X-ray

Selected condition(s) 📌

As you select screening types they will display here

Supporting documents:

📌 Supporting documents are required to process your claim. If the documents are not ready yet, you might consider canceling this claim and returning when they are ready.

**Upload documents** 📄

Continue

Back

Cancel

## Step 7

Enter the Physician and facility details. To enter a facility, select the **Accident required a hospital or other emergency care facility** box. Then, click **Continue**

**3** Physician and facility information

One last set of information to collect before completing this claim.

About the physician(s)

Name of physician

Physician's address  
Address line 1  Address line 2 (optional)

City  State  ZIP code

Physician's phone number  (123) 456-7890  
Physician's fax number  (123) 456-7890 (optional)

About the facility:

Accident required a hospital or other emergency care facility

Name of facility

Admission date  
 mm/dd/yyyy

Discharge date  
 mm/dd/yyyy

Facility address  
Address line 1  Address line 2 (optional)

City  State  ZIP code

Facility phone number  
 (123) 456-7890

## Step 8:

Confirm your responses, acknowledge the **Fraud warning** and the **Declaration and signature** and then click **Submit**

**1 Insured / Claimant information**

About you:

**Your name** Mary Spadaro  
**Your date of birth** 01/23/1980  
**Your Social Security number** \*\*\*-\*\*-1199  
**Your assigned sex at birth** Female  
**Your address** 19283 West Main Street  
Cambridge, Massachusetts 02114  
**Your phone number** (617) 718-0092  
**Your email address** mary.spadaro@companya.com

About your dependent:

**Dependent's name** Christopher Spadaro  
**Dependent's date of birth** 02/12/2007  
**Dependent's assigned sex at birth** Male

**2 Claim details**

**Date of accident** 05/16/2020  
**Details of the accident** Lorem ipsum dolor sit amet, consectetur adipiscing elit. Integer erat turpis, consequat eleifend venenatis non, porta eu enim. Ut elit nibh, varius quis imperdiet in, tristique et ligula. Pellentesque vitae convallis magna, a mattis libero. Curabitur at fermentum justo dui.

**Work related** Currently being disputed  
**Contributing factors** No  
**Selected benefit(s)** Ambulance  
Emergency room treatment  
Hospital admission  
**Supporting documents** PhysicianStmt1.pdf  
PhysicianStmt2.pdf

**3 Physician and hospital information**

About the physician(s):

**Name of physician** Dr. Adam Berkson  
**Physician's address** 123 Main Street  
Suite #29388  
Boston, Massachusetts 01181  
**Physician's phone number** 617-321-7894

**Name of physician** Dr. Suzanna Sutherland  
**Physician's address** 123 Main Street  
Suite #29390  
Boston, Massachusetts 01181  
**Physician's phone number** 617-321-7892  
**Physician's fax number** 617-321-7111

About the facility:

**Accident required a hospital or other emergency care facility** Yes  
**Name of facility** Charles Street Urgent Care  
**Admission date** 01/20/2021  
**Discharge date** 01/21/2021  
**Facility address** 123 Main Street  
Suite #29390  
Boston, Massachusetts 01181  
**Facility phone number** 617-321-0021

**Fraud warning**

Please read the fraud warning and check the box below.

Note: Checking the box below is the same as providing your signature on a hard copy document.

**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.

**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.

**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.

**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.

I certify that I have read, or had read to me, the Fraud warning for my state.

**Declaration and signature**

By checking the "Agree" checkbox below:

- I certify, to the best of my knowledge and belief, that the information I have provided in this Statement of Claim is true, accurate and complete.
- It is my intent to electronically sign and submit this Statement of Claim.
- I am applying my electronic signature to this Statement of Claim and I will be bound with the same force and effect as if I had signed this Statement of Claim on paper by hand.

Agree

**Print claim form** Please take the time to print or save this claim form for your records as you will not be able to print it later.

After you submit this claim, you will be able to add additional claims for others.

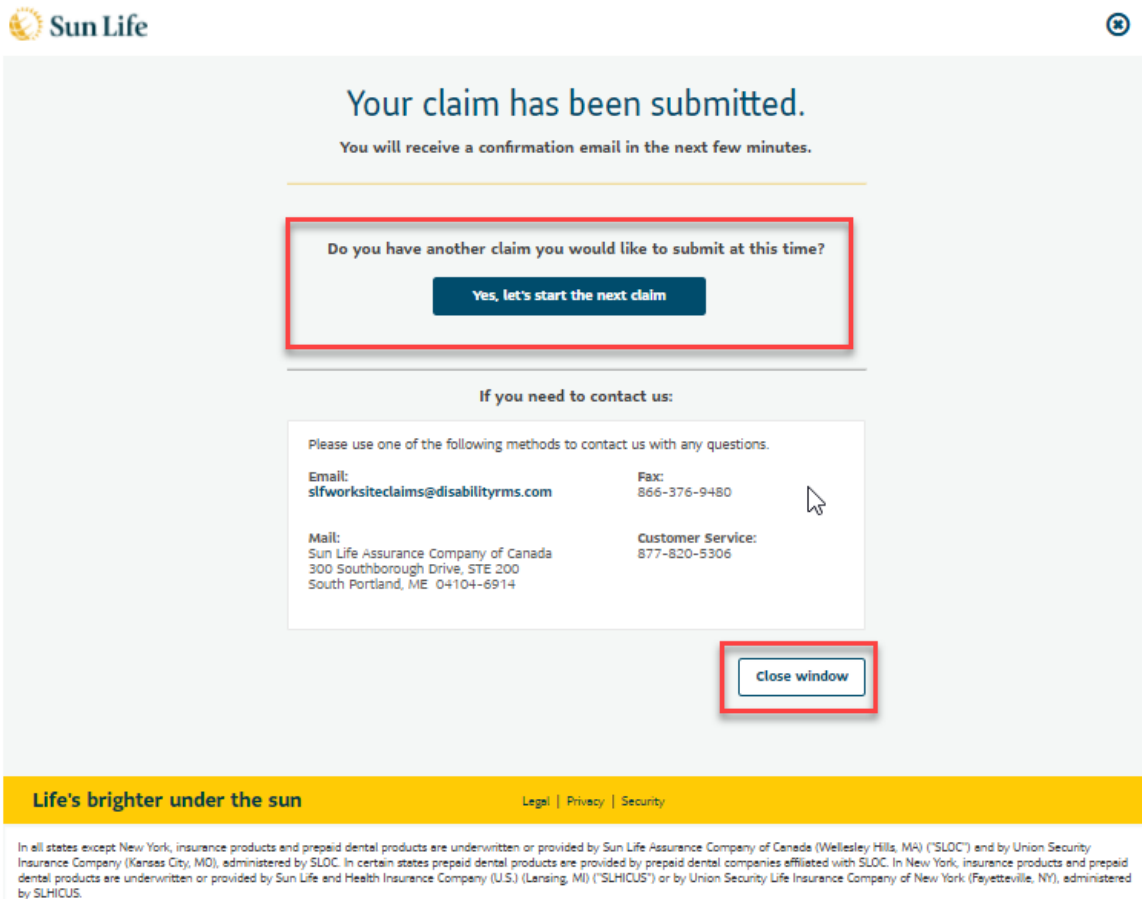
Submit

Back

Cancel

**Step 9:**

Select, Yes, let's start a new claim to initiate another claim or click Close window if you have completed your claims submissions



**Your claim has been submitted.**  
You will receive a confirmation email in the next few minutes.

Do you have another claim you would like to submit at this time?

**Yes, let's start the next claim**

If you need to contact us:

Please use one of the following methods to contact us with any questions.

<b>Email:</b> sffworksitelclaims@disabilityrms.com	<b>Fax:</b> 866-376-9480
<b>Mail:</b> Sun Life Assurance Company of Canada 300 Southborough Drive, STE 200 South Portland, ME 04104-6914	<b>Customer Service:</b> 877-820-5306

**Close window**

Life's brighter under the sun      Legal | Privacy | Security

In all states except New York, insurance products and prepaid dental products are underwritten or provided by Sun Life Assurance Company of Canada (Wellesley Hills, MA) ("SLOC") and by Union Security Insurance Company (Kansas City, MO), administered by SLOC. In certain states prepaid dental products are provided by prepaid dental companies affiliated with SLOC. In New York, insurance products and prepaid dental products are underwritten or provided by Sun Life and Health Insurance Company (U.S.) (Lansing, MI) ("SLHICUS") or by Union Security Life Insurance Company of New York (Fayetteville, NY), administered by SLHICUS.

Copyright © 2020 Sun Life Assurance Company of Canada. All rights reserved. Sun Life and the globe symbol are trademarks of Sun Life Assurance Company of Canada.

Group insurance policies are underwritten by Sun Life Assurance Company of Canada (Wellesley Hills, MA) in all states except New York. In New York, group insurance policies are underwritten by Sun Life and Health Insurance Company (U.S.) (Lansing, MI).

© 2021 Sun Life Assurance Company of Canada, Wellesley Hills, MA 02481. All rights reserved. Sun Life and the globe symbol are trademarks of Sun Life Assurance Company of Canada. Visit us at [www.sunlife.com/us](http://www.sunlife.com/us).

GVMPPG-EE-10730-a (11/21)