

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

### Step 1:

Sign into 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)



### My account

**Username**

  
**Password**

[New User? Create an account](#)

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### Individual Insurance

**Financial Professionals**  
Brokers and financial professionals with individual life insurance business  
[Sign in >](#)

**Individual Policyholders**  
Clients who have individual life insurance policies not provided through their employers  
[Sign in >](#)

By signing in, you agree to these [terms and conditions](#)  
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.

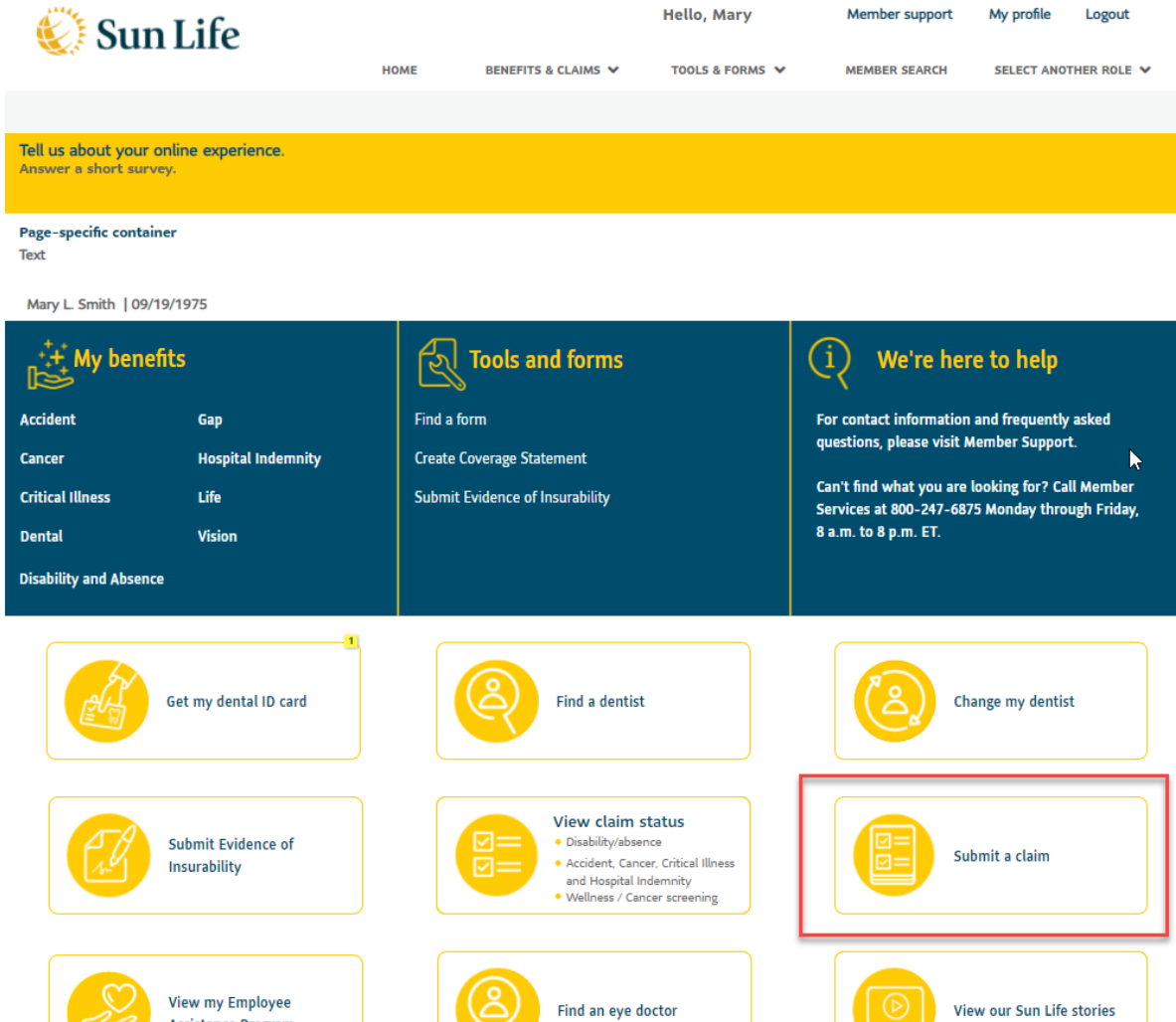
[Internet Explorer IE 11](#) [Mozilla Firefox](#) [Google Chrome](#)

**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

My benefits		Tools and forms	We're here to help
Accident	Gap	Find a form	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.
Cancer	Hospital Indemnity	Create Coverage Statement	
Critical Illness	Life	Submit Evidence of Insurability	
Dental	Vision		
Disability and Absence			

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

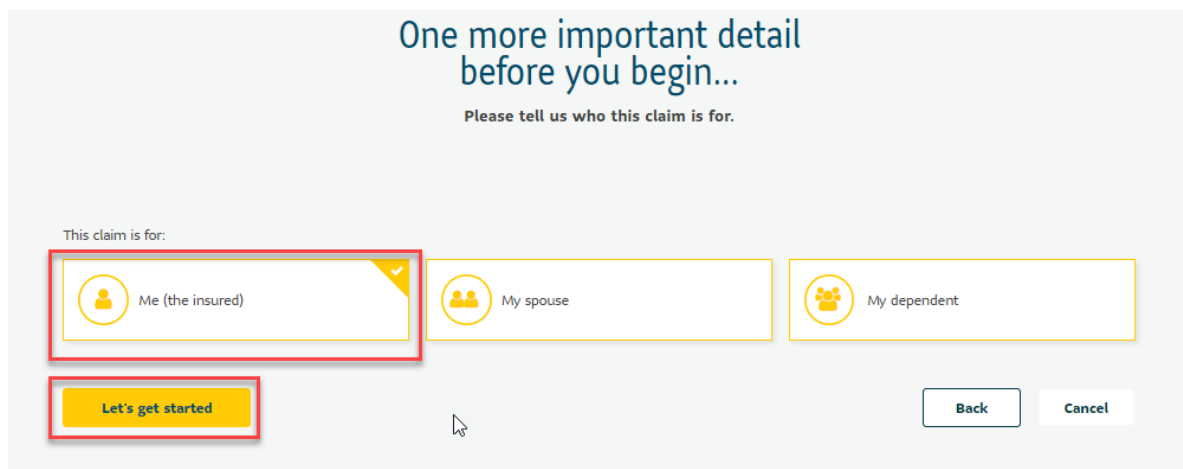
**Step 3:**

Select the box for **an Accident, Cancer, Critical Illness or Hospital Indemnity claim** 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  
\*\*\*-\*\*-\*\*\*\* Show

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 mary.spadaro@email.com  
Confirm your email address 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

**Continue** Back Cancel

**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="font-size: 0.8em;">📄</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="font-size: 0.8em;">📄</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="font-size: 0.8em;">📄</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="font-size: 0.8em;">📄</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  Physician's fax number

About the facility:

Accident required a hospital or other emergency care facility

Name of facility

Admission date

Discharge date

Facility address  
Address line 1  Address line 2 (optional)

City  State  ZIP code

Facility phone number

**Step 8:**

Select your **preferred payment method**: Direct Deposit or Check by U.S. mail. Then click **Continue**.

4 **Payment preference information**

Choose your preferred payment method for this claim

Select one ▼

Continue Back Cancel

**Step 9:**

Complete authorizations by checking “I agree” for each. Then click **Continue**.

**5 Authorizations**

Completing these authorizations will help with the time it takes to process your claim.

▼ Authorization for Release and Disclosure of Health Related Information

amiates, (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 and Health Insurance Company (U.S.), 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.

I agree, and it is my intent, to sign the above Authorization for Release and Disclosure of Health Related Information electronically. I understand that by clicking on this checkbox, I will be applying my electronic signature to this form and that I will be bound with the same force and effect as if I had signed this form on paper by hand.

▶ Authorization for Release and Disclosure of Psychotherapy notes

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

**Continue**      Back      Cancel

**Step 10:** 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** PhysicianStm1.pdf  
 PhysicianStm2.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.

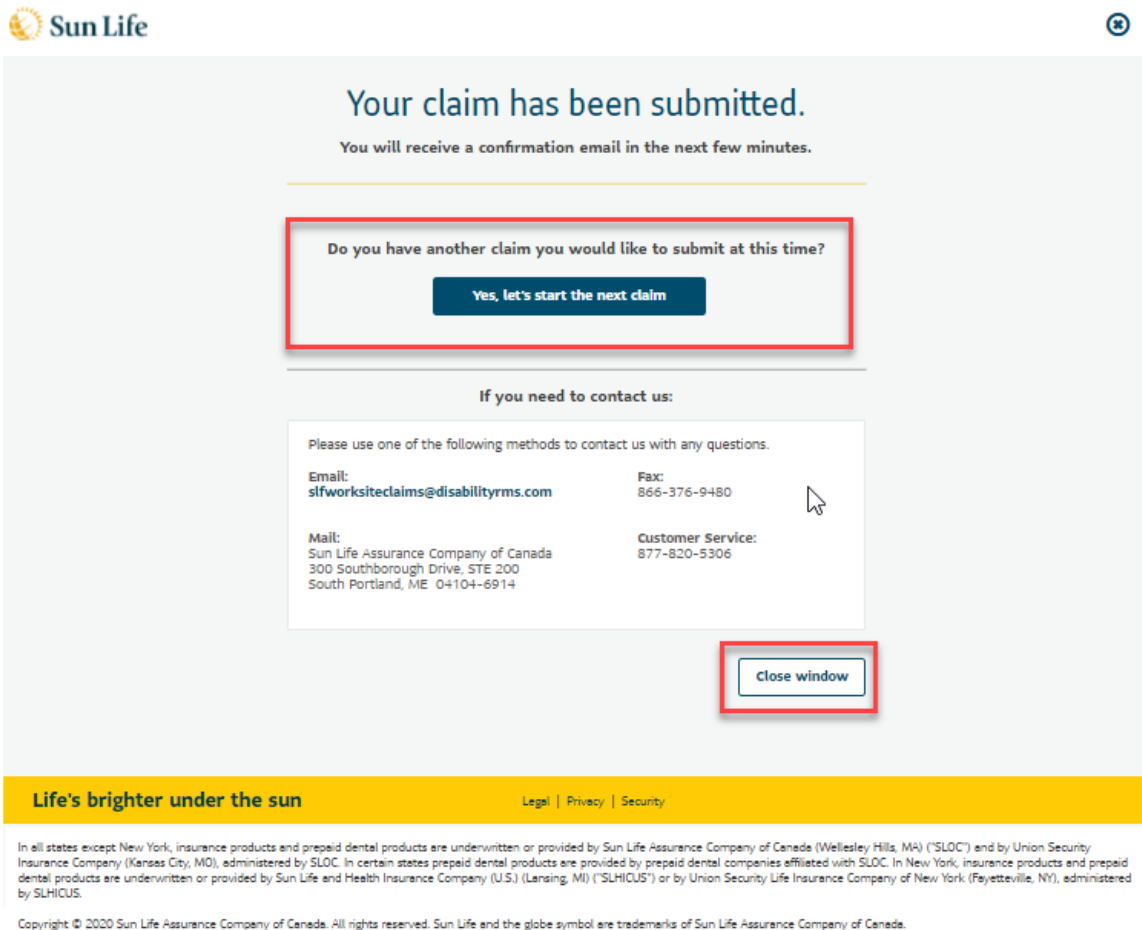
Agree

**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.

**Step 11:**

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> sflworksiteclaims@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**

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