UHIP RAMU

UHIP® application form

Sun Life Financial

Policy number
Sun Life Assurance Company of Canada – 50150

Clear

Please check one of the following:

- ☐ Student and dependant application
- ☐ Employee and dependant application
- ☐ Post-doctoral fellow application
- ☐ Extension of coverage
- ☐ OHIP waiting period
- ☐ Dependant or late dependant application
- ☐ 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 Heath Insurance Plan (UHIP®) your basic health care solution" which can be found at *www.uhip.ca*.

Please PRINT clearly.

1 Member information

Important note

Please advise your UPA immediately of any changes in your status. This includes new address, phone number, addition of dependants, etc.)

University name: Algoma University		Member ID #	
Member's last name	First name	Middle name	
Date of birth (dd-mm-yyyy)	Gender ☐ Male ☐ Female	Coverage needed ☐ One person ☐ Two persons ☐ Three or more persons	
Country of origin		E-mail address	
Canadian address (street number and name)			Apartment or suite
City	Province	Postal code	Telephone number
Member's effective date of coverage (dd-mm-yyyy)		Number of months of coverage required	

2 Dependant information

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

Last name	First name	Middle initial	☐ Male ☐ Female
Relationship	Date of birth (dd-mm-yyyy)	Effective date of coverage (dd-mm-yyyy)	Number of months of coverage required
Last name	First name	Middle initial	☐ Male ☐ Female
Relationship	Date of birth (dd-mm-yyyy)	Effective date of coverage (dd-mm-yyyy)	Number of months of coverage required
Last name	First name	Middle initial	☐ Male ☐ Female
Relationship	Date of birth (dd-mm-yyyy)	Effective date of coverage (dd-mm-yyyy)	Number of months of coverage required
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Relationship	Date of birth (dd-mm-yyyy)	Effective date of coverage (dd-mm-yyyy)	Number of months of coverage required
Last name	First name	Middle initial	☐ Male ☐ Female
Relationship	Date of birth (dd-mm-yyyy)	Effective date of coverage (dd-mm-yyyy)	Number of months of coverage required

☐ 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.

Name of alternate plan I am covered under

☐ I am covered under the above plan, but my dependants require coverage under UHIP®.
☐ I and my dependants 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 (the insurer), 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 dependants on my date of arrival. If, however, my dependants 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 dependants 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 dependants).

By signing below, I release the University from any responsibility for any undeclared dependants and for health care costs incurred by me or any of my dependants 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	Date (dd-mm-yyyy)
X	– –

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

5 Temporary proof of coverage

Shaded area to be completed by university UHIP® plan administrator

Standard enrolment		
Effective date of coverage (dd-mm-yyyy) – –	Coverage termination date (dd-mm-yyyy) – –	Premium paid/owing $
Expiry date of temporary proof of coverage (dd-mm-yyyy) – –	Name of person issuing temporary proof of coverage	Signature of person issuing temporary proof of coverage X
Late entrant/dependant enrolment		
Date from which retroactive premium is due (dd-mm-yyyy) – –	Late application fee of $500 (dependant enrolment **only**)	**$500**
Date validated (dd-mm-yyyy) – –	Retroactive premium (premium rates in effect at time of application)	$
	Premiums for remaining period of current academic year	$
	Total premium due	$

University stamp

Form not valid unless stamped

INQUIRIES Toll free: 1-866-500-UHIP (8447), Monday to Friday
8 a.m. to 8 p.m. Eastern Standard Time

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