

# Sunlife 保险申报流程

1, 用浏览器打开一下网址

<https://www.sunnet.sunlife.com/signin/mysunlife/home.wca>

2, 输入用户名和密码 并且登录

Sign in to Sun Life  
Manage your benefits, savings and investment plans with *my Sun Life*.

Sign in

输入用户名

Remember me

输入密码

Sign in

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

Need to register?  
If you already have a Sun Life product, register for *my Sun Life* to access your account online.

Register

Having trouble signing in?  
[Two-Step Verification support](#)

3, 首次登录会要求短信验证

Security code required  
We'll send the code to your phone number.

Phone number

+\* \*\*\*

How do you want to receive the security code?

Text message

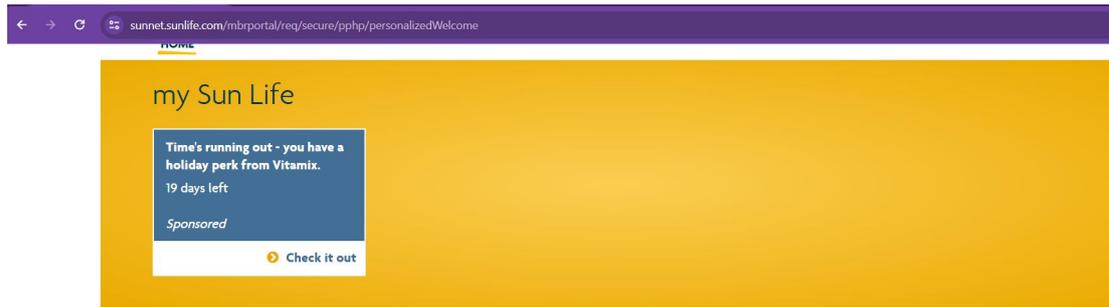
Phone call

Standard carrier fees for messaging and data may apply.

获取验证码

Get code

#### 4, 登录后点击 Submit a claim



#### Benefits

#### Benefits

Medical/Dental/Disability»102788/102788/102788



#### 5, 选择 Medical e-claim



#### Submit a claim

Your plan allows you to submit an online claim for the following types of expenses. Click on the type of claim you would like to submit:

- Prescribed Drug e-claim
- Vision Care e-claim
- Medical e-claim
- Dental e-claim
- Disability claim

GBM-E0905

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Any changes you make on this site may affect information about your particular plan offered by Sun Life Assurance Company of Canada.

## 6, 确认信息准确无误并且点击 continue

### Medical e-claim

Your plan allows you to submit an online claim for many medical expenses. Follow these **4** simple steps to submit your claim.

Please note e-claims hours of availability are as follows:  
Monday- Friday from 6 a.m. to 11:59 p.m. (Eastern Time)  
Saturday from 6 a.m. to Sunday 2 a.m. (Eastern Time)  
Sunday from 8 a.m. to 11:59 p.m. (Eastern time).

**Step 1 of 4**

- **Please check your information below.** Once your claim is processed, your claim payment will be deposited into your account and an e-mail will be sent to the address below.
- To update the information click **update**, otherwise click **continue**.

Institution	Transit	Account
CANADIAN IMPERIAL BANK OF COMMERCE COQUITLAM BANKING CENTRE 3000 LINCOLN AVE COQUITLAM, BC V3B 7L9	00920	*****1137

**E-mail Address**

ll\_fel2006@yahoo.ca

**Address**

1246 HORNBY ST  
COQUITLAM, BC  
V3E 1C5

**update** **update** **update**

**continue** **cancel**

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## 7, 同意相关条款



### Medical e-claim

#### Terms and Conditions

**Step 2 of 4**

If you accept and agree to the following terms and conditions to submit a claim online, then click **I agree to continue**.

- **Fraudulent claims are very costly for all participants in benefit plans. As administrator of this plan and for audit and investigative purposes, Sun Life Assurance Company of Canada ("Sun Life") may check the accuracy of the information given in support of your claim, and if we ask, you agree to send us the original receipts and supporting documents within the time frame requested.**
- Sun Life reserves the right to:
  - remove the online *Submit a Claim* feature and request that you send in a paper claim form with original receipts and supporting documents, and
  - request that you send in the original receipts and/or supporting documents within **12** months of you submitting your claim online.

**I agree** **cancel**

GBM-E0910

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8, 选择申报的人的姓名并将下面的项目填写成“No”后点击 continue.

## Medical e-claim Claim Options

**Step 3 of 4**

Select who the claim is for:

[Redacted Name] 

[Redacted Name]

This is a list of who is currently covered under your plan. If you have dependents you would like to add or change, please contact your Benefits Administrator.

**Provide the required information and select continue below.**

Does this person have any other coverage for this expense with Sun Life or another carrier? Yes

Are you coordinating this claim with another plan?  Yes  No 

Learn more about [coordination of benefits](#).

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9, 如果是第一次申报需要 OzMedical 到 provider 里。点击 new provider

**Step 4 of 4**

Use your receipt to answer the questions below about your claim.

The duration of a paramedical service may not appear on the receipt. If you're not sure how long it was, select 60 minutes.

**Not sure what we're asking for?** Click on the underlined column heading(s) for more information.



**Claim Information Instructions:**

Provider	Where was this service provided?	Type of Service	Service Date dd/mm/yyyy	Duration (in minutes)	Total amount (xxx.xx)	Initial Visit	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="button" value="clear"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="button" value="clear"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="button" value="clear"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="button" value="clear"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="button" value="clear"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="button" value="clear"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="button" value="clear"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="button" value="clear"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="button" value="clear"/>

Total Amount Claimed: \$0.00

I'd like to rate my experience with the providers and I agree to the [terms of use](#).

**Note**

You can enter up to eight expenses at a time. If you need to submit more than eight, you'll need to create a new claim.

You can read more about your [Medical Services](#) and the types of services you can claim.

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10, 点击 add details

## Medical e-claim Provider Information

[Go back to claim information](#)

Find your provider with **Lumino Provider Search** (recommended)

Enter your provider's location and name as it appears on your receipt.

Near:   Provider name:

The following specialties are available in Lumino Provider Search: **acupuncturist, athletic therapist, audiologist, chiropodist, chiropractor, kinesiologist, massage therapist, naturopath, occupational therapist, osteopathy, physiotherapist, podiatrist, registered dietitian, speech therapist, psychologist, social worker, psychotherapist, clinical counsellor, medical compression stockings, custom orthotics.**

### Add your provider's details

Some specialties may not be available in Lumino Provider Search. Click the button below to enter your provider's details. Check the information on your receipt to be sure it's accurate.

GBM-E0948

11, 按照箭头指示填写完善信息并且点击 continue

## Medical e-claim Provider Information

Add your provider by:

- First and last name**  
(such as your massage therapist, chiropractor or other health professional)
- Supplier/facility name**  
(such as a hospital, clinic, health store or pharmacy)

Using your receipt, enter the information below. If you're missing information, please contact the supplier or facility.

### Mandatory information:

Name of supplier/facility:

Phone Number:

Postal Code:

### Choose what this expense is for (pick all that apply):

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Ambulance                                    | <input type="checkbox"/> Diabetic supplies            | <input type="checkbox"/> Doctor's services |
| <input checked="" type="checkbox"/> Health care products and supplies | <input type="checkbox"/> Hearing aid and supplies     | <input type="checkbox"/> Hospitalization   |
| <input type="checkbox"/> Laboratory/diagnostic services               | <input checked="" type="checkbox"/> Medical equipment | <input type="checkbox"/> Nursing home      |
| <input checked="" type="checkbox"/> Orthopaedic supplies              | <input type="checkbox"/> Prosthesis                   |  |

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12, 这时候点击 providers 的下拉菜单里面应该有 OzMedical Corp. 的字样了

**Step 4 of 4**  
Use your receipt to answer the questions below about your claim.

The duration of a paramedical service may not appear on the receipt. If you're not sure how long it was, select 60 minutes.

**Not sure what we're asking for?** Click on the underlined column heading(s) for more information.

[new provider](#)

**Claim Information Instructions:**

<u>Provider</u>	<u>Where was this service provided?</u>	<u>Type of Service</u>	<u>Service Date</u> dd/mm/yyyy	<u>Duration</u> (in minutes)	<u>Total amount</u> (xxx.xx)	<u>Initial</u> Visit	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	<input type="checkbox"/>	<input type="button" value="clear"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	<input type="checkbox"/>	<input type="button" value="clear"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	<input type="checkbox"/>	<input type="button" value="clear"/>
OzMedical Corp.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	<input type="checkbox"/>	<input type="button" value="clear"/>
+ Add new provider	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	<input type="checkbox"/>	<input type="button" value="clear"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	<input type="checkbox"/>	<input type="button" value="clear"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	<input type="checkbox"/>	<input type="button" value="clear"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	<input type="checkbox"/>	<input type="button" value="clear"/>

Total Amount Claimed: \$0.00

I'd like to rate my experience with the providers and I agree to the [terms of use](#).

**Note**  
You can enter up to eight expenses at a time. If you need to submit more than eight, you'll need to create a new claim.

13, 按照发给您的 Invoice 的日期和金额填写。每一行写一个单独的 invoice。点击 continue

**Step 4 of 4**  
Use your receipt to answer the questions below about your claim.

The duration of a paramedical service may not appear on the receipt. If you're not sure how long it was, select 60 minutes.

**Not sure what we're asking for?** Click on the underlined column heading(s) for more information.

[new provider](#)

**Claim Information Instructions:**

<u>Provider</u>	<u>Where was this service provided?</u>	<u>Type of Service</u>	<u>Service Date</u> dd/mm/yyyy	<u>Duration</u> (in minutes)	<u>Total amount</u> (xxx.xx)	<u>Initial</u> Visit	
OzMedical Corp.	<input type="text"/>	Other expense	11/11/2023	<input type="text"/>	\$ 319.99	<input type="checkbox"/>	<input type="button" value="clear"/>
OzMedical Corp.	<input type="text"/>	Other expense	11/11/2023	<input type="text"/>	\$ 512.5	<input type="checkbox"/>	<input type="button" value="clear"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	<input type="checkbox"/>	<input type="button" value="clear"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	<input type="checkbox"/>	<input type="button" value="clear"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	<input type="checkbox"/>	<input type="button" value="clear"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	<input type="checkbox"/>	<input type="button" value="clear"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	<input type="checkbox"/>	<input type="button" value="clear"/>

Total Amount Claimed: \$319.99

I'd like to rate my experience with the providers and I agree to the [terms of use](#).

14, 上传对应文件, 每个都需要上传 prescription 和相对应金额的收据 (OzMedical Corp.提供)

Claim Information

**Send documents**

To continue your claim submission, please attach your receipts for each of the expenses listed below.

Have coverage and claiming for one of the following? Find out what additional information we'll need:

- [Medical braces](#)
- [CPAP/Bi-PAP machine & supplies](#)
- [Compression stockings](#)
- [Other medical equipment](#)

You can submit up to 10 documents per expense. Make sure any documents are in an approved format (.jpg, .png, .pdf) and less than 3MB in size.

**OzMedical Corp.** **\$319.99**  
Other expense  
11/11/2023

**Documents needed:**

- A medical referral issued in the last 12 months
- [Documentation](#) from your provider
- A detailed receipt

Upload files or drop them here

[Previous](#) [Continue](#) [Cancel](#)

GBM-E0951

15, 完成后点击 continue 上交并完成理赔递交。(应该有上传 prescription 和 invoice)

Claim Information

**Send documents**

To continue your claim submission, please attach your receipts for each of the expenses listed below.

Have coverage and claiming for one of the following? Find out what additional information we'll need:

- [Medical braces](#)
- [CPAP/Bi-PAP machine & supplies](#)
- [Compression stockings](#)
- [Other medical equipment](#)

You can submit up to 10 documents per expense. Make sure any documents are in an approved format (.jpg, .png, .pdf) and less than 3MB in size.

**OzMedical Corp.** **\$319.99**  
Other expense  
11/11/2023

**Documents needed:**

- A medical referral issued in the last 12 months
- [Documentation](#) from your provider
- A detailed receipt

Upload files or drop them here

[Previous](#) [Continue](#) [Cancel](#)

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