Professional Insurance Company
(In California, PIC Life Insurance Company)
Accident Insurance Plan Claim Form

Sun Life Financial®

1 Policyholder Information

Policyholder Name (Last, First, Middle Initial)			
Policy Number	Date of Birth	Social Security Number	
Mailing Address	City	State	Zip Code
Employer Name			
Employer Address	City	State	Zip Code

2 Claimant Information

Claimant Name (Last, First, Middle Initial)		
Relationship to Policyholder	Date of Birth	Employer/School

3 Claim Information

Please describe how the accident occurred.

(Auto accidents require a copy of the traffic report)

Date of Incident
Description

4 Authorization

Reminder: Please be sure to sign and return this authorization statement.

AUTHORIZATION TO OBTAIN INFORMATION: I hereby authorize any physician of the healing arts who has examined or treated me, and all hospitals, clinics or medically related facilities, insurance companies, health maintenance organizations, medical information bureau, government entity (federal, state or local) or other organization, institution or person, that has any information, records or knowledge of me or my health, past or present, to furnish to Professional Insurance Company (or its representatives) and to permit them to examine and copy any such information.
I understand that Professional Insurance Company may disclose the information in connection with underwriting or claims processing with the company. A copy of this authorization or the original, shall be valid for ninety (90) days from the date signed. I acknowledge that I have a right to a copy of this authorization upon request.

ANY PERSON WHO, KNOWLINGY AND WITH INTENT TO DEFRAUD OR DECEIVE ANY INSURANCY COMPANY FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF COMMITTING A FRAUDULENT INSURANCE ACT WHICH IS A CRIME AND SUBJECT TO CRIMINAL PROSECUTION.

Claimant's signature X	Date signed

5 Attending Physician's Statement

Physician Name			
IRS Identification Number	Phone Number	Fax Number	
Mailing Address	City	State	Zip Code

Date of Service	Procedure Code (CPT)	Place where service was performed
Diagnosis Description		

Date of Service	Procedure Code (CPT)	Place where service was performed
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Diagnosis Description		

Please describe how the accident occurred.

Date of Accident			
Description			
Hospital Name	Dates patient was confined to hospital		
Hospital Address	City	State	Zip Code

5a Physician's Disability Statement

Reminder: Please be sure to have physician sign and return this statement.

Is this condition the result of an accidental injury?	First date of total disability	Date person can return to work
Physician's signature X		Date signed

6 Employer's Disability Statement

Complete if applying for **Monthly Income Rider Benefit.**

Please be sure to have Employer sign and return this statement.

Employer's Name			
Mailing Address	City	State	Zip Code
Date of first absence	Date of return/anticipated return	Did the accident occur at work?	
Employer's signature X	Date signed	Title	

7 Additional Claim Information

Complete if filing for **Child Care Reimbursement**
Attach a receipt for reimbursement. Child care must be provided by a licensed day care; licensed after school program or licensed summer day camp program

Dependent Name (Last, First, Middle Initial)		Dates of service	Date of birth
Name of Provider		Provider Tax ID Number	
Provider Address	City	State	Zip Code

Complete if filing for **Tuition Reimbursement**
Please provide verification that the dependent is a full time student (example: copy of a bill, letter from registrar)

Dependent Name (Last, First, Middle Initial)		Dates attended	Date of birth
Name of School		School Tax ID Number	
School Address	City	State	Zip Code

Complete if filing for **Wellness Benefit**
Please attach a copy of the bill including diagnosis

Claimant Name (Last, First, Middle Initial)	Date of Service
Name of Provider	