

For our Retirees

Rio Algom and BHP Billiton are currently working to bring all employee and retiree groups under one benefits provider. To make sure that we can keep offering you the same great level of extended health and dental coverage, we have appointed Sun Life as your new provider.

Your benefits will stay exactly the same. Beginning January 1, 2009 any new expenses will be submitted to Sun Life on new forms using your new policy number, 23505. As well, you should have received your new Direct Pay Drug Card in the mail on or about April 1, 2009. If you have not received your Drug Card or have changes to personal information, want to confirm your eligibility for Health or Dental benefits or have retirement or pension inquiries please contact:

Benefits Call Center 1-888-351-5755

(M-F 8:00am to 8:00pm Eastern Time)

OR

www.bhpbillitonbenefits.tractusweb.com

For inquiries on health or dental claims please contact:

Sun Life 1-800-361-6212

We appreciate your patience during this period of transition and extend our thanks to the local pharmacies and medical community who have been helpful to our retirees during this transition.

Electronic claims forms are provided on the following pages.

Dental Claim Form



Approved by the Canadian Dental Association

Sun Life Assurance Company of Canada, a member of the Sun Life Financial group of companies, is committed to keeping your information confidential.

1 To be completed by Dentist

P A T I E N T	Last Name	Given Name	Unique Number	Spec.	Patient's Office Account No.	I hereby assign my benefits payable from this claim to the named dentist and authorize payment directly to him/her. _____ Signature of Subscriber	
	Address		Apt.		D E N T I S T		
	City	Prov.	Postal Code				
Phone No.:							
For Dentist's Use Only - For additional information, diagnosis, procedures, or special consideration. Duplicate Form <input type="checkbox"/>				I understand that the fees listed in this claim may not be covered by or may exceed my plan benefits. I understand that I am financially responsible to my dentist for the entire treatment. I acknowledge that the total fee of \$ _____ is accurate and has been charged to me for services rendered. I authorize release of the information in this claim form to my insuring company / plan administrator. _____ Signature of Patient (Parent/Guardian)			
Office Verification/Dentist's Signature							
For Plan Administrator Use Only							
Date of Service		Procedure Code	Intl Tooth Code	Tooth Surfaces	Dentist's Fee	Laboratory Charge	Total Charges
Day	Month						
This is an accurate statement of services performed and the total fee due and payable E & OE				TOTAL FEE SUBMITTED			

2 To be completed by Member

You must complete this section.

Member Information

Contract Number	Member ID				
23505					
Last Name		Given Name		Date of Birth (d/m/y)	<input type="checkbox"/> Male <input type="checkbox"/> Female
Street Address				Daytime Telephone Number ()	
City		Province	Postal Code	Evening Telephone Number ()	

3 Spouse and Children Covered by this Claim

Complete only if claim is for your spouse or child.

Spouse's Full Name				Date of Birth (d/m/y)			
				<input type="checkbox"/> Male <input type="checkbox"/> Female			
Child's Name	Relationship to you		Date of Birth			Complete for overage dependents (refer to benefit information for age limits)	
	Son	Daughter	Day	Month	Year	Disabled	Full-time Student
	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>

4 Co-ordination of benefits

Indicate if your Spouse and/or children has coverage under any other dental plan or contract.

Is your spouse and/or children covered for any of these expenses under any other dental plan or contract?		
No <input type="checkbox"/>	Yes <input checked="" type="checkbox"/>	Spouse's date of birth (d/m/y): _____
If yes:		
<ul style="list-style-type: none"> You must submit a claim for your spouse to his/her plan first. You must submit a claim for your child first under the plan of the parent with the earliest birthday (month and day) in the calendar year 		
If your spouse's plan is also with us:	Contract Number _____	Member ID: _____
Do you want us to co-ordinate benefits (process both claims)?		
		No <input type="checkbox"/> Yes <input checked="" type="checkbox"/>
If yes, Spouse's Signature: <u>X</u>		Date (d/m/y) _____

5 Details of Claim

If the cost of your treatment will exceed the pre-determination limit in your benefit plan, you should send an estimate to Sun Life Assurance Company of Canada. To determine if you will be reimbursed for the treatment, have your dentist complete a Pre-Treatment Form (available from your dentist).

1. Are any expenses the result of an accident?		No <input type="checkbox"/>	Yes <input checked="" type="checkbox"/>	If yes, complete the following:	
When and where did the accident occur (d/m/y): _____		Work <input type="checkbox"/>	Home <input type="checkbox"/>	Other <input type="checkbox"/>	
How did the accident occur?					
Are any expenses the result of a condition covered by a workers' compensation program?		No <input type="checkbox"/>	Yes <input type="checkbox"/>		
2. Is this treatment for orthodontic purposes?		No <input type="checkbox"/>	Yes <input type="checkbox"/>	Implants?	No <input type="checkbox"/> Yes <input type="checkbox"/>
3. Crowns, Bridges, Dentures		Is this the initial placement?		No <input type="checkbox"/>	Yes <input type="checkbox"/>
If No,		Date of prior placement (d/m/y): _____		If Yes, Date teeth were extracted	
Reason for replacement: _____		(for denture or bridge (d/m/y): _____)			
Please include the following to facilitate handling of your claim:		<ul style="list-style-type: none"> Pre-treatment x-rays (for crowns, bridges, veneer, inlays, onlays) List of all missing teeth (for bridges only) 			

6 Authorization and Signature

You must complete this section.

Fraudulent claims are very costly for all participants in benefit plans. As Administrator of this plan, we may check the accuracy of the information given in support of your claim.

Note for Members: As part of the benefits payment and plan management process, we exchange information about claims with you, including claims for goods or services received by your spouse and dependents. This includes details such as the date of the claim, what the claim was for, and the amount of the claim. Please ensure that your spouse and/or dependents are aware of, and consent to this process prior to submitting claims.

I certify that all goods or services being claimed have been received by me, and if applicable, my spouse and/or dependents. I certify that the information in this form is true and complete and does not contain a claim for any expense previously paid for by this or any other plan.

I authorize Sun Life Assurance Company of Canada, its agents and service providers to use and exchange information about me, and if applicable, my spouse and/or dependents, needed for underwriting, administration and adjudicating claims under this Plan with any other person or organization who has relevant information pertaining to this claim including health professionals, institutions, investigative agencies, insurers and reinsurers. I understand that information pertaining to this claim may be reviewed in the event this Plan is audited.

If this claim is being made on behalf of my spouse and/or dependents, I am authorized to disclose information about them, for the purposes of underwriting, administration and adjudicating claims. I confirm that my spouse and/or dependents, if any, also authorize Sun Life Assurance Company of Canada to disclose information about their claims to me, for the purposes of assessing and paying a benefit, if any, and managing my group benefits plan.

I agree that a photocopy or electronic version of this authorization shall be as valid as the original.

Member's signature	Date (d/m/y)
X	

For details specific to your plan, consult your benefit information package or visit our Web site,

www.sunlife.ca

Mail the completed form to the nearest Sun Life Assurance Company of Canada Health Claims office:

Sun Life Assurance Company
of Canada

PO Box 6076 Stn CV
Montreal QC H3C 4S3

Sun Life Assurance Company
of Canada

PO Box 3417 Stn D
Ottawa ON K1P 1G1

Sun Life Assurance Company
of Canada

PO Box 2880 Stn Main
Edmonton AB T5J 4S6

For more information call 1- 800-361-6212

Please retain a copy of your claim form and receipts for your records.

Extended Health Care Claim Form



- Sun Life Assurance Company of Canada, a member of the Sun Life Financial group of companies, is committed to keeping your information confidential.
- Use this form for **all** medical expenses and services. For dental expenses, please use the *Dental Claim Form*.

- Please print clearly and be sure all sections are complete to avoid delays in processing your claim.
- Attach the **original** receipt for each expense claimed and keep photocopies for your records.
- Sign on page 2 and mail your claim to the address at the bottom of page 2. Some plans allow claims to be submitted online at www.sunlife.ca

Questions? Please visit www.sunlife.ca
or call 1-800-361-6212 Monday – Friday, 8 a.m. – 8 p.m. ET

1 Information about you

Be sure to fully complete this section.

Contract number 23505		Member ID number		Your plan sponsor/employer BHP Billiton	
Your last name			First name		<input type="checkbox"/> Male <input type="checkbox"/> Female
Your address (street number and name, apartment or suite)					Date of birth (dd/mm/yy)
Your address (street number and name, apartment or suite)			City		
Province	Postal code	You'd prefer correspondence in <input type="checkbox"/> English <input type="checkbox"/> French		Daytime phone number ()	

2 Are you or your spouse covered under another plan?

Complete this section if you or your spouse are covered under another plan. Send your claims to your own plan first. When you receive your claim statement, send a copy plus copies of your receipts to your spouse's plan to claim any unpaid amount. Send your spouse's claims to their plan first, then send a copy of their claim statement and receipts to your plan. Send your children's claims first to the plan of the parent whose birthday falls earlier in the year.

► Is your spouse a member of another benefit plan?

No Yes If yes, please provide details below.

Spouse's last name		First name		Date of birth (dd/mm/yy)	
Type of coverage <input type="checkbox"/> Single <input type="checkbox"/> Family	Are you claiming any expenses that are NOT covered under your spouse's plan? If yes, please specify:			<input type="checkbox"/> No <input type="checkbox"/> Yes	
If your spouse's benefit plan is with Sun Life Financial, do you want us to process the claim through both benefit plans? <input type="checkbox"/> No <input type="checkbox"/> Yes ►			Contract number	Member ID number	

Spouse's signature X			Date (dd/mm/yy)		
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► Are you also a member of another benefit plan?

No Yes If yes, please provide details below.

Type of coverage <input type="checkbox"/> Single <input type="checkbox"/> Family	Are you claiming any expenses that are NOT covered under your other plan? If yes, please specify:		What is your employment status under your other benefits plan? <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Retired		
If your other benefit plan is with Sun Life Financial, do you want us to process the claim through both benefit plans? <input type="checkbox"/> No <input type="checkbox"/> Yes ►			Contract number	Member ID number	

3 Information about your claim

List the names of all persons for whom you're claiming expenses. Add up all the receipts and insert the total amount claimed. Ensure each receipt clearly indicates the type of expense being claimed.

Person for whom you are making the claim	Date of birth (dd/mm/yy)	Relationship to you	Full-time student	Disabled	Amount claimed
Claimant (last name, first name)			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
Claimant (last name, first name)			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
Claimant (last name, first name)			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
Claimant (last name, first name)			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
Claimant (last name, first name)			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
					Total claimed
					\$

► Are you attaching receipts for out-of-Canada expenses? No Yes

If yes, tell us the date of departure from claimant's home province. Ensure the currency and amount are clearly marked on each receipt. We'll assess your claim and convert the eligible expenses to Canadian dollars.

Date (dd/mm/yy)

Out-of-Canada expenses claimed
\$

► Are any of the expenses you're claiming the result of a work injury? No Yes

If yes, did you submit your claim to the workers' compensation plan in your province, if applicable? No Yes

► Are any of the expenses you're claiming the result of a motor vehicle accident? No Yes

If yes, did you submit your claim to the automobile insurance plan in your province, if applicable? No Yes

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Please ensure that your spouse and/or dependents are aware of, and consent to this process prior to submitting claims.

I certify that all goods or services being claimed have been received by me, and if applicable, my spouse and/or dependents. I certify that the information in this form is true and complete and does not contain a claim for any expense previously paid for by this or any other plan.

I authorize Sun Life Assurance Company of Canada, its agents and service providers to use and exchange information about me, and if applicable, my spouse and/or dependents, needed for underwriting, administration and adjudicating claims under this Plan with any other person or organization who has relevant information pertaining to this claim including health professionals, institutions, investigative agencies, insurers and reinsurers. I understand that information pertaining to this claim may be reviewed in the event this Plan is audited.

If this claim is being made on behalf of my spouse and/or dependents, I am authorized to disclose information about them, for the purposes of underwriting, administration and adjudicating claims. I confirm that my spouse and/or dependents, if any, also authorize Sun Life Assurance Company of Canada to disclose information about their claims to me, for the purposes of assessing and paying a benefit, if any, and managing my group benefits plan.

I agree that a photocopy or electronic version of this authorization shall be as valid as the original.

Member's signature X	Date (dd/mm/yy)
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Mailing instructions – keep a copy of your claim form and receipts for your records

Mail your completed form to the claims office nearest you.

Sun Life Assurance Company of Canada

PO Box 6076 Stn CV
Montreal QC H3C 4S3

Sun Life Assurance Company of Canada

PO Box 3417 Stn D
Ottawa ON K1P 1G1

Sun Life Assurance Company of Canada

PO Box 2880 Stn Main
Edmonton AB T5J 4S6