Administration Guide

for Client-administered group plans

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Use this guide if you use your own system to self-administer your benefits and prepare your own billing statements.

Our guides are stored and regularly updated on our **Plan Sponsor Services** home page.

Sun Life

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Introduction

As a plan administrator, you have an important role to play. This guide describes the procedures to follow for the day-to-day administration of your plan. Use the guide in conjunction with your contract and benefit booklet. These practices help to ensure that we provide coverage and pay benefits according to your plan. We also provide the following guides, if applicable to your plan:

- Plan Sponsor Services User Guide
- Data File Transfer Guide(s)
- Health Spending Account Administration Guide
- Personal Spending Account Administration Guide

The information you need to provide depends on which administration option you use:

- **Self Administered** — you maintain your plan member records and send us data for confirming claims eligibility, and you prepare your own premium bill; or
- **Plan Sponsor Services** — you maintain your plan member records directly on our online administration system, and we prepare your monthly premium bill based on the information supply.

A key part of your role is to provide us with all necessary plan member information on a timely basis so we can pay claims and prepare your monthly premium bill (if applicable to your administration arrangements). All plan member enrolment forms, and beneficiary designations, are kept at your location.

We've designed this guide based on a standard Sun Life benefit plan. You can ignore information about benefits or terms that don't apply to your plan.

Note: This guide does not replace the terms and conditions of your group benefits plan. It's your role to administer your plan according to the terms within your contract and benefit booklet.

Be sure to give us your company name and contract number when you contact us. If you are writing us about a plan member, make sure you include:

- Plan member's full name and
- Member ID

Protecting plan members' privacy

We're committed to protecting your plan members' personal information. Our global privacy commitment specifies a common and consistent set of principles that all Sun Life companies follow. All of our representatives must comply with our code of conduct.

Our privacy policy and code for Canada is on our website at **sunlife.ca**. It includes obligations related to the collection, use and disclosure of personal information. Unless we have the plan member's consent, we don't disclose personal plan member information to third parties. Some examples are:

- Plan sponsors
- Doctors
- Workplace medical or health centre staff

Even when we have consent, we'll only disclose information in some situations. As the administrator of your benefits plan, you may need to handle documents that contain personal information. Please keep up that same level of respect for the privacy of all plan member data.

Assigning plan member ID

An important element of protecting your plan members' privacy is to ensure that you assign a unique ID number to each of your plan members. This applies whether the plan member is in a different billing group or location, or falls under a separate payroll or administration system. Reassigning a previously used ID could put a plan member's privacy at risk.

To help protect your plan members' privacy, keep the following in mind when assigning ID numbers:

- Do not use plan members' Social Insurance Number (SIN) as their member IDs.
- Terminated plan member IDs can't be assigned to an active plan member, regardless of when the previous plan member was terminated.
- Assigned numbers can't be reused, even if assigned in error. If you encounter a situation where a number has been assigned in error, contact Group Benefits Administration Team.
- Discontinued plan member IDs can't be reassigned. For example, if you decided to change plan member IDs from numeric to alphanumeric, you can't use the old numeric IDs for another group of employees.
- ID numbers must be unique for all plan members covered under a contract number, regardless of whether the plan member is in a different billing group or location, or falls under a separate payroll or administration system.
- IDs must be a maximum of 11 characters, numeric or alphanumeric. If you have a Pay-Direct Drug plan, the ID number must be a maximum of 10 characters.

Who is eligible?

This section will help you determine plan member and dependent eligibility. You need to refer to your contract for specific details.

Plan member
To be eligible for coverage, plan members must be permanent employees, residing and working in Canada, be actively at work and meet the eligibility requirements outlined in your contract. To be eligible for Extended Health Care benefits, they must be covered under a provincial or federal medicare plan.

Spouse
Refer to your contract for your plan's definition of spouse. Members can only cover one spouse at a time.

Dependent children
Plan members' children and spouses' children are eligible dependents if they are not married or in any other formal union recognized by law and are under the age limit specified in your contract. Eligible children include natural children and legally adopted children.

Notes:
- Foster children are not eligible dependents. The province provides benefits for them.
- Other children who are in the custody of a member (not their natural child) are not automatically covered. Refer to **Maintaining Plan Member Records** section under Coverage for children other than plan member/spouse's children.

Overage student
Dependent children are eligible until they reach the upper age limit, if they aren't married or in any other formal union recognized by law, so long as they are full-time students at an educational institution recognized under the Income Tax Act (Canada). Students don't have to live with the plan member or even attend a school in their province to maintain dependent status. However, they must be covered under a provincial or federal medicare plan (to be eligible for Extended Health Care) and be dependent upon the plan member for support. (See your contract for age limits and other details.)

Notes:
- If an overage dependent child, not currently covered, returns to school full-time, they are eligible for coverage while they remain a student until they reach the plan's upper age limit.
- If an overage dependent attends school outside of Canada, you must request an administrative exception to continue coverage. (See **Administrative exceptions** section.)

Disabled dependents
If a dependent is disabled before your plan's age limit, coverage can be continued provided he or she:

- Is incapable of financial self-support because of a physical or mental disability, and
- Depends on the plan member for financial support, and is not married or in any other formal union recognized by law.

To be eligible, a **Disabled Child Coverage** form needs to be completed and sent to us within 6 months of the date the dependent reaches the age limit.

Types of plans and effective dates

To enrol all eligible plan members according to your contract terms, please refer to the participation level specified in your contract.

Determining effective dates

If your contract/booklet includes a waiting period, plan members must satisfy that waiting period before their coverage takes effect. The waiting period is calculated from the first day of employment provided the plan member is continuously employed during that period.

Plan members must be actively at work on the date coverage would normally begin for coverage to become effective. Dependents can't be confined in a hospital on the date coverage would normally begin. This doesn't apply to newborns.

Note: If a plan member goes off sick during the waiting period, they don't need to restart the waiting period on their return.

Participation level of 100% (mandatory benefit plan)

Benefits take effect on the day after plan members satisfy the waiting period and other eligibility requirements.

Participation level of anything other than 100% (non-mandatory benefit plan)

Ensure you process plan member enrolments in a timely manner. The effective date of their coverage is determined by the following:

If we receive the enrolment form*	**Then the effective date is**
On or before the date the plan member becomes eligible	The date the plan member becomes eligible
Within 31 days of the date the plan member becomes eligible	The date the **Enrolment** form is received
More than 31 days after the date the plan member becomes eligible. **The plan member is considered a late applicant**. The plan member and the plan member's eligible dependents must complete a **Health Statement** form to verify proof of good health.[1]	The date the **Health Statement** form is approved. There may be a restricted maximum for Dental. We will notify you in writing whether the application is approved.[2]

* Sun Life uses the date the **Enrolment** form is signed as the date received, unless we receive the **Enrolment** form more than two months after the date the plan member becomes eligible. In this case, a **Health Statement** form is required,

[1] If a resident of Québec, the plan member must be covered under a private plan if one is available. Extended Health Care coverage begins on the date the employee becomes eligible for the coverage.

[2] If the Extended Health Care coverage is declined, the plan member and the plan member's eligible dependents are still covered for Dental Care.

The Régie de l'assurance maladie du Québec (RAMQ)

If your contract contains health, accident or disability benefits and you have a place of business in Québec, your contract must comply with Québec Drug Insurance Plan requirements. This means the drug portion of the Extended Health Care benefit must at least match the basic drug plan provided by the Québec government, and plan members' participation is compulsory for both plan member and dependent coverage (unless the plan members and dependents have coverage elsewhere, e.g. spouse's plan).

Combined mandatory and non-mandatory plans

We'll base the benefits effective date on the rules specified above, for each type of plan.

For coverage that requires proof of good health (see Enrolling in the plan section)

Benefits are effective on the later of:

- the date the plan member qualifies, or
- the date we approve the Health Statement

When a plan member refuses coverage

As a result of comparable coverage:	Other than for comparable coverage:
• Plan members refuse Extended Health Care and/or Dental Care benefits because they have comparable coverage under another group plan.* Plan members may refuse coverage for themselves and their dependents, or their dependents only.	• Mandatory plan – Plan members cannot refuse coverage if the plan is mandatory. • Non-mandatory plan – A plan member may refuse all coverage or all dependent coverage, but plan members can't pick and choose benefits.

*The most common type of comparable coverage is a spouse's plan. But, a plan member could also be covered under another group plan, as an active employee or a retiree.

Non-mandatory plan: Plan members must provide you with all refusals in writing, for future reference. Make sure the plan member completes and signs a **Refusal for Group Coverage** form. This will prove that you offered them coverage, and they refused it.

Reinstating a former plan member

- If your contract contains re-employment conditions (e.g. six months), the waiting period isn't required for plan members re-employed within the number of months indicated in the contract. The reinstated plan member will have the same level of benefits as prior to termination. Coverage may be reinstated on the date of re-employment.
- If re-employment is outside the number of months specified in your contract, the plan member will need to satisfy the waiting period set out in your contract from the date of re-employment and complete a new enrolment form. The plan member will have to reapply for any optional coverage.
- The plan member's previous claims history and maximums will also be in place upon their reinstatement whether or not they returned to work within the reinstatement period.

The reinstatement rules follow the mandatory or non-mandatory plan rules outlined earlier. The same reinstatement rules also apply to plan members, returning to work from a leave of absence, who did not have coverage during that leave.

Enrolling in the plan

It's good practice to enrol plan members in your benefits plan as soon as they're hired. This applies even if they'll need to go through a waiting period before they qualify for coverage.

We highly recommend you provide us with employee email addresses. We use email addresses to notify Plan Members about the status of their claims. Email addresses also make it faster for Plan Members to register on the Sun Life website and the **my Sun Life mobile app**.

All plan members will be able to register for an online account at Sunlife.ca or mysunlife.ca using their employee email address.

The Enrolment form

Step 1 Fill out the first section of the **Enrolment form** for each plan member.

Step 2 Have the plan member fill out the remaining sections of the form and return it to you.

Step 3 Review the form is complete and signed.

Step 4 These forms are part of the member records file.

Step 5 You're responsible to provide plan members a benefit booklet, all information pertaining to their benefits plan and any other documentation you normally provide. Plan members may have access to their benefit booklet, drug, travel and Member ID cards at **mysunlife.ca**.

Step 6 Provide plan members with information about their disability plan. This includes the benefit calculation formula, definition of disability, exclusions and pre-existing conditions. This information is included in the **Disability Insurance – Important information** document located under Claim form >> Disability Insurance - Important information.

Note: For plan members in Québec, distributing this information is a regulatory requirement.

Reminder: it is your role and responsibility to:

- Provide plan information to plan members, but not advice
- Refer plan members to Sun Life or to a licensed advisor if they are asking about their coverage needs
- Refer plan members to Sun Life if they have questions about their claims.

More about the Enrolment form

If you maintain positive enrolment data, detailed dependent information is entered on our claims system for validating claims eligibility. The spouse details and children details sections of the **Enrolment form** must also be fully completed.

Plan members who refuse Extended Health Care and/or Dental because they have comparable coverage (e.g. under their spouse's plan) should complete the refusal section of the form.

When proof of good health (Health Statement) is required

A **Health Statement** form is required when:

- a plan member is a late applicant (see **Determining effective dates**),
- a plan member originally refused benefits in a non-mandatory plan and is now applying for coverage,
- a plan member is applying for Optional Life or Optional Critical Illness benefits, or
- the Life or Long-Term Disability amount exceeds the non-evidence maximum (NEM).

Your contract/booklet will indicate if your plan has an NEM. If your plan has NEM coverage, your plan member must submit proof of good health when they first apply for coverage that exceeds the NEM amount.

Submitting a Health Statement form

Step 1 Complete "Part 1 – Plan Administrator Information" and then give the form to the plan member for completion.

Step 2 Advise the plan member to answer all questions on the form to ensure coverage is not delayed. If applicable, the spouse and/or dependent sections of the form must also be completed.

Step 3 The information requested on the **Health Statement** form is highly confidential. Advise the plan member to send the completed form directly to us. Mailing instructions are provided on the form.

When we make our decision

We'll notify you in writing whether the application is approved.

If the application is approved:

- A confidential letter will be sent to the plan member advising of our decision.
- If you use our **Plan Sponsor Services** for your benefits administration, we will update the approved coverage directly on our administration system.
- If you have a self-administered plan and prepare your own premium billing, make the necessary premium adjustments.

Until you receive written confirmation from us that the plan member's application has been approved for the amount of coverage requested, do not make payroll deductions for the coverage under review.

If the application is declined: The plan member will receive a confidential letter. The letter will detail the reasons for our decision.

If additional information is required:

- A confidential letter will be sent to the plan member requesting the required information.

If the plan member does not provide the requested information, we will advise the plan member that the file will be closed.

If your plan has optional benefits

Your plan may include optional benefits like Optional Life, Optional Accidental Death & Dismemberment and Optional Critical Illness. We usually need the plan member to complete a **Health Statement** for optional benefits.

Coverage becomes effective on the later of the following dates:

- the plan member or dependent is eligible, or
- we approve the **Health Statement**.

If your plan has Critical Illness

Provide the plan member with the application if they are:

- applying for Optional Critical Illness, or
- a late applicant for Critical Illness

The application includes an enrolment section and a health statement. Mailing instructions are provided on the form.

Optional Insurance cancellation

A plan member can cancel Optional Insurance at any time. If they cancel within 30 days from the effective date of coverage, any premium paid by the plan member must be returned.

Naming a beneficiary

If your contract includes Life benefits, the plan member needs to designate a beneficiary stating the beneficiary's full name and relationship to the plan member.

1. What is a primary beneficiary?
   A primary beneficiary is any individual, institution, trust or charity the plan member names. The primary beneficiary is first to receive the life benefits payable under the plan. The plan member may name several primary beneficiaries and specify how the life benefit will be divided amongst them.

2. What is a contingent beneficiary (or secondary beneficiary)?
   The contingent beneficiary is any individual, institution, trust or charity the plan member designates to receive the life benefit under the plan if the primary beneficiary dies before the plan member. If there is more than one primary beneficiary, then the contingent beneficiaries will not receive any life benefit unless all primary beneficiaries pass away before the plan member. The plan member may name several contingent beneficiaries, and specify how the life benefit will be divided amongst them.

To name or change a beneficiary designation, a new designation must be made.
An employee can:

- use the Sun Life digital beneficiary tool.
- complete, date and sign a new form.
- use a digital tool provided by the Plan Sponsor (designed in-house or through a TPA-Third Party Administrator)

Note: When a plan member updates their beneficiary, ensure that they're not attmepting to change a previous nomination of an irrevocable beneficiary. (Please see details on irrevocable beneficiaries below.)

The Sun Life Digital Beneficiary tool

The Sun Life Digital Beneficiary tool is available to clients who use **Plan Sponsor Services**.

The digital beneficiary tool allows plan members to view and update their designation online at any time. There are no paper forms to mail.

The digital beneficiary tool is available on:

- the profile page on **mysunlife.ca** or
- the Member enrolment tool if applicable to your administration

To enter a nomination in the digital beneficiary tool, plan members will require:

- access to **mysunlife.ca**
- life benefits

Plan members can enter designations in 2 ways:

1. Same beneficiary for all benefits:
- the named beneficiary will apply to all the plan member's life benefits at time of death (i.e. the nomination will apply to benefits selected both before and after the nomination is made).
- if the plan member wants to nominate a different beneficiary for any new benefits, they can update their nomination by selecting the Different beneficiary for each benefit option.

2. Different beneficiary for each benefit:
- plan members can enter a different beneficiary by benefit.
- plan members will have to designate a beneficiary for each new benefit. If the plan member fails to name a beneficiary for a benefit, then any payment for that benefit will default to the estate.

Plan members with an irrevocable beneficiary will be blocked from making updates online, even if they enrol in new coverage.

- plan members will still need to complete a paper Beneficiary form and a Consent by Beneficiary form to ensure proper consent.

There is no option to enter a beneficiary for Optional Spousal Life. The member will receive the benefit for any Optional Spousal Life.

- If a member wants to nominate someone else, they can request the **Beneficiary for Optional spouse life benefits** form.

Using the Sun Life Digital Beneficiary tool

- Encourage plan members to use the Sun Life digital tool, but we'll still accept paper forms.
- If a plan member submits a paper beneficiary form, you must enter the designation in the **Plan Sponsor Services** website:
  - ensure the date the form is signed is later than the time/date stamp of the last digitally submitted nomination
    NOTE: You can view nominations but are unable to make updates in the digital beneficiary tool.
  - add a space between the letters 'l' and 'r' of a beneficiary name that contains the consecutive letters 'irr'.
  - ensure you include 'revocable' or 'irrevocable' for a beneficiary with a relationship of spouse, in the province of Québec.
  - if a plan member names an irrevocable beneficiary, ensure 'irrevocable' is included, in all provinces.
  - if plan member adds an irrevocable beneficiary using the 'Same beneficiary for all benefits' option, a consent form will still be required if changing beneficiary for a newly added benefit.
- You must still retain previously submitted paper forms (enrolment, change or beneficiary) or scans made in compliance with e-commerce legislation. You will be asked to provide these at time of claim.

Electronic beneficiary (e-beneficiary) designations, electronic signatures (e-signature)

This section applies if you allow your employees to:

- name beneficiaries on a system that you or a third party administrator hosts (e-beneficiary),
- digitally sign a PDF (e-signature), or
- use an application such as DocuSign or OneSpan (e-signature).

You need to accept, store and manage these designations in a manner or on a system that complies with:

- electronic commerce law, and

- the CLHIA Process on Electronic Declarations dated December 2019 (Please see appendix B).

Technology that captures an e-signature or a system that allows for an e-beneficiary must include security measures to:

- allow your employees to verify their identity (secure sign-in) and authenticate themselves
- link the e-signature to the document
- uniquely link the designation to your employee
- allow you to detect the location from which the designation is sent (IP address)
- allow your employees to access, view and change the designation
- store the designation to protect against unauthorized access by a third party
- detect any changes to the designation
- affix a date/time stamp to the designation
- acknowledge receiving the designation by e-mail (to a known and trusted email) or other means
- alert your employee of any changes to the designation by e-mail (to a known and trusted email) or other means

Ensure that you have reliable administrative practices. We need to know about prior and current designations. Your processes should include measures to:

- review and store any existing paper designations
- safeguard prior and current designations
- accept paper when necessary or as an option for employees who ask for it
- prevent:
  - employees with existing irrevocable beneficiaries from making changes without the irrevocable beneficiary's consent
  - designations by Powers of Attorney;
- verify the employee's email address that they use to send a PDF:
  - encourage use of work email because it is secure and only the employee has access
  - if designation received through a personal email address, confirm receipt by work email
  - if neither of the above are possible, you need to be confident that the designation is indeed from the employee
- allow you to securely transmit beneficiary designations to Sun Life at time of claim (e.g., PDF or screen shot that include date and time stamp).

It's a good idea to consult with your legal advisors when allowing e-beneficiary or e-signature.

Scans

Sun Life will accept scans of paper designations, made in compliance with e-commerce legislation, at time of claim. Please send securely.

Designation requirements

Designations, whether customized paper forms or digital must:

- tell employees whether their designation applies to all benefits or if different beneficiaries can be named for different benefits (e.g. basic life/accidental death and optional life/optional accidental death)
- tell employees we will pay the estate if they do not name a beneficiary
- allow employees to name a trustee for a beneficiary under 18 years old. Include wording to tell employees:
  - to name a trustee for children under 18 except in Québec
  - in Québec, payments to minors will be made to parents on their behalf; trustees are not applicable
- ensure that employees can make their beneficiary designations revocable
- tell Québec employees that:
  - designation of their legal spouse is irrevocable unless clearly marked revocable
  - they will not be able to change their designation or reduce their life insurance coverage without the written consent of the irrevocable beneficiary.

Revocable and irrevocable beneficiaries

Revocable beneficiary means that the plan member may change their beneficiary designation at any time. A beneficiary is assumed to be revocable unless specifically designated as irrevocable.

In Québec, a spouse by marriage or a civil union is considered revocable only if the word "revocable" is specified in the designation or a revocable box is checked.

Irrevocable beneficiary is a type of beneficiary designation. An irrevocable beneficiary has rights that other beneficiaries don't have. A plan member can't replace an irrevocable beneficiary unless the irrevocable beneficiary agrees. Similarly, a plan member needs their consent if the plan member wants to reduce the irrevocable beneficiary's share of the life benefit. A plan member may designate anyone as an irrevocable beneficiary, regardless of the relationship to the plan member.

A beneficiary designation may be irrevocable for the following reasons:

- **Irrevocable by provincial law** — In the province of Québec, a legally married spouse or civil union spouse designated as the beneficiary is presumed to be irrevocable unless the word revocable is specified in the designation or a revocable box is checked.
- **Irrevocable at the member's request** — A plan member may designate a beneficiary as irrevocable by including the word irrevocable in the designation or by checking an irrevocable box. For example, John Doe, Spouse (Irrevocable) - 100%.
- **Irrevocable by court ruling** — A beneficiary designation could be made irrevocable by a court ruling. For example, a term of a divorce decree may require that the spouse must remain as the beneficiary and cannot be changed without the spouse's consent. The plan member must designate the court mandated beneficiary and include the word irrevocable in the designation or check an irrevocable box.

Changing an irrevocable beneficiary includes:

- changing the current irrevocable beneficiary to another beneficiary,
- reducing the amount of coverage payable to the irrevocable beneficiary;
- changing the current beneficiary designation from irrevocable to revocable.

To change an irrevocable designation, the plan member must submit one of the following documents:

- Consent by Beneficiary form, signed by the irrevocable beneficiary, revoking their rights;
- Final Decree of Divorce (see Beneficiaries in Québec table below);
- Proof of death of the irrevocable beneficiary.

Note: If you have changed the design of your plan and this plan negatively impacts the irrevocable beneficiary, then consent is not required. For example, if you lower the amount of basic life insurance for your plan members from $50,000 to $25,000, then despite a lower life benefit payable to the Irrevocable Beneficiary, the consent of the Irrevocable Beneficiary is not required.

Beneficiaries in Québec

The following table will help you understand when a beneficiary change is allowed when a legal spouse has been designated as a beneficiary.

Spouses designated after 20/10/76

Current beneficiary designation	Can be changed to
Spouse designated on or after 20/10/76 is revocable if the word revocable is included in the designation or a revocable box is checked.	Any beneficiary
Spouse designated on or after 20/10/76 is irrevocable, unless the word revocable is included in the designation or a revocable box is checked.	Cannot be changed unless: • A waiver was signed • Divorce was granted between 20/10/76 and 1/12/82 terminating the spouse's rights, or • Divorce was granted on or after 1/12/82

Spouses designated before 20/10/76

Current beneficiary designation	Can be changed to
Husband designated between 1/7/70 and 20/10/76 whether the word revocable is included or not	Any beneficiary
Husband designated between 1/7/70 and 20/10/76 with the word irrevocable included	Cannot be changed unless: • A waiver was signed; • Divorce granted between 20/10/76 and 1/12/82 terminating the husband's rights, or • Divorce was granted on or after 1/12/82
Husband designated before 1/7/70	Any beneficiary
Wife designated before 20/10/76, and divorce granted before 20/10/76	Any beneficiary
Wife designated before 20/10/76, but divorce granted between 20/10/76 and 1/12/82	Child until 20/10/77; thereafter the wife is irrevocable except if she waived her rights or if divorce terminated her rights
Wife designated before 20/10/76, but divorce granted after 1/12/82	Any beneficiary after the date of divorce

More about beneficiary designations

The following chart contains beneficiary examples. In the event of a trust, sophisticated or complex designations, please advise the plan member to consult with their legal, financial advisor or licensed insurance advisor.

Scenario	Additional information
Designating one beneficiary	To designate one beneficiary, the plan member must complete the name and relationship of the beneficiary.
Designating more than one beneficiary	To designate more than one beneficiary, the plan member must complete the name and relationship and percentage on the form for each beneficiary. The total of the designated percentages must equal 100 percent. An equal distribution will be assumed if there are no percentages indicated.
If your plan has Optional Life benefits	The plan member may designate separate beneficiaries for Basic Employee Life, and Optional Employee Life. The plan member needs to complete each of the applicable sections of the **Enrolment** form or **Beneficiary Nomination** form. If the plan member wishes to designate the same beneficiary for basic and optional benefits the employee can complete the 'Same beneficiary for all benefits' form. The plan member is the beneficiary by default for any Optional Spousal benefit.
Appointing a contingent beneficiary	To appoint a contingent beneficiary, the plan member needs to complete the Contingent Beneficiary section of the **Enrolment** form or **Beneficiary Nomination** form. A contingent beneficiary is the person designated to receive the proceeds if the primary beneficiary dies before the insured.
Designating a minor child in Québec	In Québec, a plan member may NOT designate an administrator (or trustee). The proceeds will be paid to the parent(s) or other legal tutor if the beneficiary is a minor at time of death of the parent(s).
Designating a minor child in all other provinces	To designate minor children under the age of 18 as beneficiaries, a trustee must be designated. If no trustee is named, proceeds may be paid into court.
Designating an estate	A plan member designating the estate needs to consider the following: • The insurance proceeds, may be subject to estate taxes. • Insurance proceeds payable to the estate are subject to claims from creditors, whereas proceeds payable to a named beneficiary may be protected from creditors. • Probate costs vary from province to province and are based on the total value of the estate (except in Québec). These costs are not incurred if proceeds are payable to a named beneficiary.
When no beneficiary has been designated	Proceeds will be paid to the plan member's estate.

Note: Plan members cannot name a bank or financial institution as their beneficiary for purposes of providing collateral for a loan.

Maintaining plan member records

It is very important that plan member information is kept up-to-date at all times. This ensures that your monthly premiums are totaled based on the most recent changes. It also helps us to process and pay claims accurately.

Recording plan member changes

The effective date must be recorded for all changes affecting a plan member's coverage such as:

- salary changes (when coverage is based on earnings),
- class/location change,
- change in family status (e.g. from single to family),
- adding dependents (newborns, change in spouse, etc.),
- change in spousal coverage,
- student information, and
- termination of coverage.

Notes:

- When a plan member record is changed in our administration system, the new data is transferred to our claims system. Then, it transfers to our pay-direct drug system. No claims should be submitted until the update is complete.
- If you administer your plan on your own system and submit your member data to us by member eligibility file transfer or Excel list, we update our claims system. The new data is then transferred to our Pay-Direct Drug system.

Change from single to family status

When a plan member wants to change from single to family status, consider your plan type:

- **Mandatory benefit plan** – The change effective date is the date of the plan member's status change, i.e. date of marriage, adoption, birth of a child, etc.

- **Non-mandatory benefit plan**

If the plan member requests change from single to family due to an event such as birth, adoption, marriage:	**Then the effective date is:**
On or before the date of the event	The date of the event[2]
Within 31 days of the event	The date of the event[2]
More than 31 days after the date of the event – the plan member's dependents are late applicants and must complete a **Health Statement** form to verify proof of good health[1]	The date the **Health Statement** form is approved, and we will notify you of the approval. (There may be a restricted maximum for Dental.)[3]

[1] A Health Statement form is required for any existing dependent not already covered.
[2] If a resident of Québec, the plan member must be covered under a private plan if one is available. Extended Health Care coverage begins on the date the employee becomes eligible for the coverage.
[3] If the Extended Health Care coverage is declined, the plan member's eligible dependents are still covered for Dental Care.

Adding or removing dependents, newborns, change in spouse, etc.

Positive enrolment — New dependent information needs to be updated or claims will be rejected.

Non-positive enrolment — When a plan member already has family coverage, new eligible dependents are added when claims are submitted.

Coverage for children other than plan member/spouse's children

It will be up to you to ensure that the plan member is:
- financially responsible for the dependent
- responsible for the care and well being of the dependent

You can add the dependent if the above criteria is met. The effective date is the date the plan member takes financial responsibility or legal guardianship of the child.

It will be up to you to obtain proof, and maintain their records. Your legal counsel can help with what proof is required. You don't have to complete the **Request to Continue Coverage** form.

Please note that Foster Children aren't eligible and don't follow the above guidelines, as the Province provides benefits for them.

Updating student information

Coverage for a dependent child ends at the lower age limit specified in your contract/booklet unless the dependent child meets the criteria to continue coverage as an overage student. See the "Determining eligibility" section for the definition of an overage student.

To qualify as an overage student:

- their learning institute must consider them a full-time student.
- We'll also consider:
  1. co-op programs, and
  2. apprenticeship programs, but the overage student must not receive Employment Insurance (EI) while in school.

An overage student doesn't have to be living with the plan member to qualify as a dependent. They can be earning an income during their studies.

You must notify us if coverage for a dependent child is to continue past the lower age limit. You can do this:

- through the Sun Life's online Plan Sponsor services site
- through your HRIS file feed to Sun Life
- through your Tape file feed to Sun Life
- by contacting our Group Benefits Administration Team

We'll update our system to show the dependent child is an overage student. You'll have to let us know if their status changes in the future.

Coverage for an overage dependent ends on the:
- first day of the next term if the student does not return to full-time studies
- date the student graduates
- date the student stops attending school (i.e. discontinues their education)

We'll allow coverage to continue through the summer term, if the student is returning to their studies in September. At least once a year, confirm overage dependents are still enrolled in a learning program full-time and will be enrolled full-time for the upcoming year.

If your policy includes dependent life, we may ask for proof of enrolment if we receive a death claim. We'll use it to verify that a dependent qualifies for a claim payment.

The plan member must keep their dependent status up-to-date.

How to determine if a school or college is an accredited institution?

Visit the website listed in the table below, to see a list of the accredited institutions:

In Canada	Outside Canada
http://cicic.ca/868/search_the_directory_of_educational_institutions_in_canada.canada	http://cicic.ca/976/get_information_on_applying_to_study_abroad.canada

Adding coverage that was initially refused

Event	Mandatory plan	Non-mandatory plan
Other coverage ends (e.g., spouse's plan)	Coverage start date should be the day after the other coverage (e.g., spouse's plan) ends	• Coverage start date needs to be the day after the other coverage ends. The plan member must request coverage within 31 days of this date. • If coverage is not requested within 31 days after the other coverage ends, the plan member is considered a late applicant. The plan member and their eligible dependents must complete a **Health Statement** to provide proof of good health. There may be a restricted maximum for Dental.[1,2,3]
Plan member requests coverage after initially refusing	Coverage start date should be the original effective date	The plan member is considered a late applicant. The plan member and their eligible dependents must complete a **Health Statement** to provide proof of good health. There may be a restricted maximum for Dental.[1,2,3]

[1] If a resident of Québec, the plan member must be covered under a private plan if one is available. Extended Health Care coverage begins on the date the employee becomes eligible for the coverage.
[2] To add a late applicant, Sun Life requires the Enrolment form.
[3] If the Extended Health Care coverage is declined, the plan member and the plan member's eligible dependents are still covered for Dental Care.

Reductions due to age or retirement

Coverage may reduce or terminate at a certain age or at retirement, depending on the benefit.

You have the obligation to contact your members when they experience a reduction in Basic Life or Optional Life (if applicable) coverage. This can include, but is not limited to, the following scenarios:

1. when coverage reduces at a specific age
2. change in role which results in a reduction of salary
3. retirement

You're responsible to notify plan members that they can apply to convert Life insurance to an individual policy. Plan members may be eligible for our Choices life product. We'll let them know about the Choices options for health and critical illness coverage too. (See **Purchasing individual insurance when benefits end or reduce** section.)

Check your contract/booklet for the definition for what is deemed as retirement and the Retirement Date, as well as plan specifics for reduction and termination in coverage.

Terminating coverage

Coverage terminates when a plan member's employment ends or if the plan member is no longer actively working. Your contract specifies when coverage terminates. (See **Premiums – Plan Member Terminations** section)

Our systems will automatically update the plan member benefits when:
- the plan is set up with a life reduction
- a benefit is scheduled to terminate at retirement (if you have provided the retirement date)
- a benefit is scheduled to terminate based on age

You need to notify us when:
- a plan member takes early retirement (if you have not provided the retirement date or it changes)
- a plan member on LTD with another carrier reaches age 65

You're also responsible for notifying eligible plan members of their right to apply to convert their Life to an individual insurance policy. Plan members may be eligible for our Choices life product. We'll let them know about the Choices options for health and critical illness coverage too. (See **Purchasing individual insurance when benefits end or reduce** section.)

Changing a beneficiary designation

To name or change a beneficiary designation, a new designation must be made. (See **Naming a beneficiary** section.)

Plan members who are approved for disability

If you use our **Plan Sponsor Services** for your benefits administration, we will update our systems to reflect the premium waiver for the appropriate benefits when:

- a plan member is receiving Long-Term Disability benefits, or
- a Waiver of Life Premium is approved

Statutory leave

Your contract allows you to continue coverage while a plan member is on statutory leave. The continuation of coverage provision in your benefit plan helps you comply with your legal obligations to continue coverage under minimum standards legislation. Check with your legal advisor if you are uncertain about your obligations to continue coverage under such legislation.

You'll need to make arrangements to collect any premiums required from plan members.

Continuing coverage during a leave

- You don't need to notify us if all coverage is continuing for the province's legislated statutory leave period.
- You must notify us if the plan member chooses to cancel:
  - all benefits
  - non-taxable LTD
  - optional benefits

  They'll need to sign Sun Life's waiver and release form.
- Refer to the **Administrative exceptions** section if coverage is being requested beyond the province's legislated statutory leave period.

If a plan member terminates coverage during their leave and they return to work within the province's legislated statutory leave period:

- Previous benefits coverage should be immediately reinstated when they return to work. We will not enforce the waiting period.
- Reinstatement of coverage follows the mandatory/non-mandatory plan rules outlined earlier. (See **Types of plans and effective dates** section.)

If a plan member terminates optional coverage and/or non-taxable LTD coverage

- If your plan member re-elects optional coverage when they return to work, they'll need to complete a **Health Statement**.

About RAMQ:

Your contract must comply with Québec Drug Insurance Plan requirements if: your contract contains health, accident or disability benefits and you have a place of business in Québec

This means the drug portion of the Extended Health Care benefit must at least match the basic drug plan provided by the Québec government. Plan members must participate in the plan to get plan member and dependent coverage (unless plan members and dependents have coverage elsewhere: e.g. spouse's plan).

If a plan member dies

If a plan member dies, provide us with the date of their death. We'll continue benefits for the survivors based on the terms of your contract, if provided under your plan. Let the survivors know they can continue to submit claims under the plan member's contract number and ID. We'll terminate the coverage at the end of the survivor period.

Survivors must follow the instructions found in the **Submitting Claims** section.

Adding or changing Optional Life benefits

If your plan has optional benefits, plan members may decide to add them after they've enrolled. Or they may choose to increase the amount of optional coverage they initially chose. Below are the steps your plan member must take to add or change optional benefits.

- The plan member must complete the optional benefits section of the **Enrolment** form. They must also complete a **Health Statement**.
- If electing optional benefits for the first time, make sure that the plan member nominates a beneficiary.
- A plan member or spouse who has declared themselves a smoker and later stops smoking can request non-smoker status by completing a non-smoking declaration.

Voluntary termination

A plan member may cancel all coverage or **all** dependent coverage, if the plan is non-mandatory. (See **When a plan member refuses coverage**.) A plan member may also cancel optional benefits at any time. Coverage will terminate on the later of the date the request is received or the requested effective date.

Purchasing insurance when benefits end or reduce

There are insurance and health benefit options available when coverage ends or reduces.

A Sun Life Individual policy

- must apply within 31 days of the group coverage ending/reducing
- applicable to the plan member and their spouse
- plan members residing in Québec are eligible to convert dependent child life
- no proof of good health is required
- the conversion provision is subject to certain conditions that are outlined in the contract or stipulated in any applicable legislation

My Life Choice

- must apply within 60 days of the group coverage ending/reducing
- applicable to the the plan member and their spouse
- a few health questions are required
- there are a number of rules and conditions that apply

Health Coverage Choice

- must apply within 60 days of the group coverage ending
- applicable to the the plan member, their spouse and their children
- options include health and dental coverage
- no proof of good health is required

Choices Critical Illness

- must apply within 60 days of the group coverage ending
- applicable to the the plan member, their spouse and their children
- no proof of good health is required

You're responsible for letting plan members know about their right to apply to convert their benefits.

You need to complete the **Insurance options for plan members on termination of group benefits** form, to confirm that the plan member qualifies.

Let plan members know as soon as possible so they don't miss the deadline.

For more information go to https://www.sunlife.ca/en/choices/

Who to call

Plan members can call 1-877-893-9893.

Administrative exceptions

To provide coverage outside the terms of the group benefits contract, you need to request an **administrative exception** (admin exception). Usually, admin exceptions deal with situations that impact individual plan members regarding eligibility or continuation of coverage beyond contract terms.

Waiver of waiting period

Requests to waive waiting periods should be directed in writing to your Group Service Representative. We will consider a request to waive the waiting period if:

- it is made within 31 days of the hire date, and
- the waiver applies to all benefits.

Admin exceptions

From time-to-time, you may need to request an **administrative exception** (admin exception). Usually, admin exceptions apply to continuing coverage for more time than the contract allows. This is not the only type of admin exception but the most common.

In some provinces, you must extend coverage during a statutory leave when your plan member contributes their share of the premiums. In other provinces, this is not the case. Regardless of whether you are legally required under minimum standards legislation to extend coverage, you must complete the **Plan Sponsor Request to Continue Coverage** form for:

- Dependent child studying outside of Canada
- Maternity/Parental leave
- Other legislated leaves
- Statutory notice period for termination of employment
- Temporary lay-off/Personal leave
- Waiver and Release*

Access to form

Please refer to your contract for further details

Other admin exceptions

For the following admin exceptions contact your Sun Life representative:

- mass termination
- coverage during a strike or lockout
- request for out-of-country coverage extension

*This applies when the plan member is entitled to have coverage extended, but opts out.

Employer Contributions and Taxable Benefits

This information is not tax advice. We recommend you seek advice about tax reporting the benefits you provide to your employees or other plan members.

The Canada Revenue Agency (CRA) and Revenu Quebec (RQ) explain when there's a taxable benefit and information about:

- how to calculate the value of the taxable benefit,
- what to include in the calculation,
- when to include in the employee's income, and
- where to include on the tax slip.

Please refer to the information posted on the respective government websites for full details about tax reporting on workplace benefits. We've provided the links below *.

Certain employer contributions are added to the employee's income. The table below gives an overview when a group insurance contract exists.

This table is not an exhaustive list and may not represent all the benefits or services available to employees.

Legislation	**Employer contributions included on tax slips**	**Employer Contributions not included on tax slips**
Income Tax Act (Canada)*	• Group life insurance • Group sickness or accident insurance plans (e.g., Critical Illness, Accidental Death & Dismemberment) • Personal Spending Account	• Disability benefits (short and long-term) – when disability payments are taxable income • Private health services plan, such as Medical, Dental and Health Spending Account
Income Tax Act (Québec)*	• Group life insurance • Group sickness or accident insurance plans (e.g., Critical Illness, Accidental Death & Dismemberment) • Personal Spending Account • Private health services plan benefits (e.g., Medical, Dental and Health Spending Account)	• Disability benefits (short and long-term) – when disability payments are taxable income • Private health services plan benefits (e.g., Medical, Dental and Health Spending Accounts) when the benefits are **for the surviving spouse**

*Based on CRA & RQ information dated in November 2022. Please use these links for up to date details:

Canada.ca: Employers' Guide, Taxable Benefits and Allowances

RevenuQuebec.ca: Taxable Benefits

Premiums

Premiums are due on the first of the month. Premiums must be paid within the grace period specified in your contract. If you don't pay your premiums within this grace period, claim payments could be suspended until we receive payment .

How premiums are calculated

Premiums are calculated for complete months only.

Premiums are not payable for the first month of coverage if the effective date is after the first of the month. For example:

- If the plan member's coverage is effective on January 1, premiums are payable as of January 1.
- If the plan member's coverage is effective on January 2, premiums are payable as of February 1.

Premiums are payable for the last month of coverage if the termination effective date is after the first of the month. For example:

- If the plan member's coverage is terminated on January 1, premiums are payable up to and including December.
- If the plan member's coverage is terminated on January 2, premiums are payable for the month of January.

As a self-administered client, you're responsible for preparing your own billing statements.

Preparing your monthly premium statement for remittance to Sun Life

PREMIUM AMOUNT FROM LAST PREMIUM STATEMENT:	
Plus New plan members	Add all new, rehired and any plan members who were missed
Plus Increase in amount of coverage	Add any increases in member coverage. i.e.: salary increases, increased work hours or class changes
Less Plan members on disability	Subtract the premiums for the benefits for which premiums are waived when a member is receiving Long-Term Disability benefits or when Life waiver is approved
Less Plan member terminations or deaths	Subtract plan members who have been terminated, died or had their coverage cancelled
Less Decrease in amount of coverage	Subtract any decreases in member coverage. i.e.: salary decreases, demotions, decreased work hours or class changes
Equals current premium	
Plus Back charges	Add premiums (amounts for previous months) for plan members who were not reflected on previous statement
Less Back credits	Subtract any premiums (amounts for previous months) for plan members who were not removed from previous statement
Equals total premium payable	This provides the rate details by plan and benefit.

Premium Payment Options:

Once you have completed your premium statement, corresponding payment can be sent via bank wires or electronic funds transmission (EFT).

Please contact your Sun Life representative for bank account details.

If you opt for EFT or Wire, to ensure prompt payment allocation, Sun Life requires 24 - 48 hours notice. Payment notification should be sent to pa.cheque@sunlife.com, including the policyholder name and contract number in the subject line. The email should also include your premium statements.

In addition, we also accept cheques.

Using a customized premium statement

If you choose to use your own customized premium statement, please send a copy to your Sun Life service representative for approval. Our billing team will review the statement to ensure it contains all the required information.

We require the following information on all premium statements:

- Contract policy number and billing location
- Plan sponsor name
- Premium due date
- Certification of all provincial sales taxes including zero amounts
- For each benefit provide the following:
  - Number of plan members
  - Amount of coverage
  - For dependent based benefits, premium coverage must be itemized separately
  - Monthly premium rate
  - Premium for current month
  - Back charges (+)
  - Back credits (-)
  - Premium amount owing
- Total premium owing (sum of all benefits)
- Provincial sales taxes, broken down by participating provinces / territories (if applicable)
- Total amount payable

Calculating salary-based benefits

Although some plans may round the salary first and then complete the calculation, our standard is to:

- Multiply the benefit formula by the plan member's:
  - annual salary for Life and AD&D,
  - weekly salary for Short-Term Disability and
  - monthly salary for Long-Term Disability.
- Round up the calculated amount of coverage.

Example:

Annual salary	$30,445
Benefit formula	2x annual salary
Round to	the next $1,000

Calculation:

Multiply	$30,455 x 2 $60,910 (amount of coverage)
Round to	$61,000

If the premium rate is expressed as a percentage of payroll then the volume is the plan member's eligible payroll amount not the amount of coverage.

Plan Member Terminations

Plan member terminations should be submitted within 3 months of the actual termination.

Today's date	**Anniversary date**	**Termination date**	**Termination date to use**
		Is after the last anniversary date	the actual termination date
May 1, 2021	January 1, 2021	April 18, 2021	April 18, 2021
	3 or more months ago	is before the last anniversary date	the last anniversary date
May 1, 2021	January 1, 2021	October 15, 2020	January 1, 2021
	less than 3 months ago	is before the last anniversary date	today's date minus 3 months
May 1, 2021	March 1, 2021	February 15, 2021	February 15, 2021

If you use our **Plan Sponsor Services** for your benefits administration and billing, and the premium adjustment date is not the plan member's actual termination date please submit a Special Request advising us of the plan member's actual termination date.

Waiver of premium for plan members on disability

Premiums are charged for all benefits while a plan member is receiving Short-Term Disability. They are also charged for all benefits while a plan member is applying for Long-Term Disability and/or Waiver of Life Premium.

Once a plan member is receiving Long-Term Disability benefits, premiums are not charged for their Short-Term Disability or Long-Term Disability coverage.

If a plan member is approved for the Waiver of Life Premium, premiums are not charged for their Employee or Dependent Life and Accidental Death & Dismemberment benefits. Premiums continue to be charged for Extended Health Care, Dental and Critical Illness coverage. Refer to your contract or booklet for benefits eligible for waiver of premium.

Submitting claims

At Sun Life we offer plan members and providers a number of ways to submit claims:

- **mysunlife.ca**
- **my Sun Life Mobile app**
- **Sun Life Connect Provider eClaims Portal**
- **Electronic Data Interchange** (**EDI**) - at the dental office
- **Pay direct drug claims** - at the pharmacy
- **Mail** - personalized claim forms available on **mysunlife.ca**

We assess claims based on the information you or your plan members send to us. So, it's important that you help us keep our records up-to-date. We must receive them within the time limits specified in your contract.

Note: Plan members should check their claim statement to ensure they actually received the services that were claimed.

Coordinating benefits with other plans

Plan members can coordinate their medical and dental expenses with other plans to maximize their benefits.

Claims for plan members and their spouses: The plan under which the person is covered as an employee pays first. If the person is covered as an employee under two plans, the following order applies:

- the plan where the person is covered as an active, full-time employee.
- the plan where the person is covered as an active, part-time employee.
- the plan where the person is covered as a retiree.
- the plan where the person is covered as a dependent pays last.

Claims for dependent children should be submitted in the following order:

- the plan where the child is covered as an employee.
- the plan where the child is covered under a student health or dental plan provided through an educational institution.
- the plan of the parent with the earlier birth date (month/day) in the calendar year pays before the plan of the parent with the later birth date (month/day) in the calendar year (e.g. if the plan member's birthday is in June and the spouse's birthday is in March, the spouse's plan pays before the plan member's plan).
  - if both parents' birthdays fall on the same month and day, the plan of the parent whose first name begins with the earlier letter in the alphabet.

The above order applies in all situations except when parents are separated or divorced and there is no joint custody of the child, in which case the following order applies:.

- plan of the parent who has custody of the child (the plan member should note on the claim form that they have custody of the child),
- plan of the spouse of the parent with custody of the child (the plan member should note on the claim form that they have custody of the child),
- plan of the parent who does NOT have custody of the child (the plan member should note on the claim form that they do not have custody of the child), and
- plan of the spouse of the parent without custody (the plan member should note on the claim form that they do not have custody of the child).

Submitting coordination of benefits (COB) claims online: Plan members can submit COB claims on **mysunlife.ca** when Sun Life is the second payer. They can also have COB processed automatically between both plans when their spouse or partner is also covered under a Sun Life plan.

Note: Plan members cannot submit COB claims using **my Sun Life Mobile app**.

The amount of benefit payable under the second plan cannot exceed the total amount of eligible expenses incurred LESS the amount paid by the first plan.

If both spouses' benefit plans are administered by Sun Life, the plan member can ask us to pay from both benefit plans as part of the same claim process.

If a dental accident occurs, health plans with dental accident coverage will pay benefits before the dental plan.

Extended Health Care

Extended Health Care benefits cover necessary medical expenses that aren't covered by provincial hospital and medical plans (see your contract for more details).

Hospitals normally submit claims for **hospital expenses** directly to us, and we pay the hospital directly.

Out-of-province medical expenses

Plan members should keep their **Travel card** with them at all times. They must call Sun Life's Emergency Travel Assistance provider **before** they incur a medical emergency expense.

To make a claim for **emergency medical expenses**, while traveling out-of-province, plan members must:

- contact Sun Life's Emergency Travel Assistance provider, immediately
- follow the instructions in their Travel Benefit pamphlet (available at **mysunlife.ca**)

To claim non-emergency, out-of-province medical expenses, plan members must submit an **Extended Health Care Claim**.

Paramedical services (e.g. chiropractor or physiotherapist)

Receipts must include:

- name of practitioner,
- type of practice,
- length of visit,
- charge for the service,
- practitioner's licence, registration number or other recognized credentials,
- date of service, and
- name of person who received the service.

If your plan requires it, the plan member must attach a written recommendation and referral from the doctor.

Medical services and equipment

Certain services require a doctor's letter that include:

- name of doctor,
- name of patient,
- date of diagnosis,
- patient's present level of mobility (if applicable),
- length of time equipment is required,
- prognosis of condition,
- equipment required and reason why,
- if requested, explanation why an electric device is required.

The plan member needs to attach the original receipts showing these expenses were paid in full. Also include proof of payment from the provincial health plan, if applicable.

Nursing services

Bayshore Health Care manages program that offers nursing care services to plan members.

Contact Sun Life's Client Care Center for inquiries or to request nursing services. Sun Life will send a request to Bayshore on the client's behalf. Bayshore will contact the plan member to evaluate their needs and submit documents to Sun Life's claim office.

Pay-Direct Drug plans

A pay-direct drug card simplifies the prescription drug claim process. It reduces the plan member's out-of-pocket expenses. Plan members can show their drug card to the pharmacist and if the drug is eligible, we'll pay the amount covered by the plan.

A drug card is available on:
- **mysunlife.ca**
- **my Sun Life Mobile app**

Note: Plan members can only use their drug cards within Canada. If a plan member needs to fill a prescription while traveling, they can submit a claim when they return to Canada. We will assess the claim and convert the eligible expense amount to Canadian dollars.

When the drug card does not work at the pharmacy

Issue	Solution
Incorrect date of birth	Check birth date entered by pharmacist. If claim is still rejected, check birth date recorded at Sun Life.
Incorrect relationship code	Relationship codes are different for the plan member, spouse, dependent child, overage student and disabled dependent child. Check relationship code entered by pharmacist.
Benefits are being coordinated, and your plan is second payor	Drug claims can be coordinated electronically at the pharmacy ONLY if both the plan member and spouse have Pay-Direct Drug plans.
The prescribed drug is not covered	Not all prescription drugs are covered under your plan. The pharmacist can contact the doctor to see if an equivalent drug can be prescribed.

If the plan member receives less than the amount they expected

They have purchased a brand-name drug instead of a generic substitution, and your plan covers only up to the cost of generic drugs.

The pharmacy charges more than the "reasonable and customary" limit typically charged in their regional area for dispensing fee or ingredient costs. ("Reasonable and customary" limits are applied on a number of expenses to ensure your plan does not incur unnecessary cost when providers charge excessive fees.)

Maximum drug supply covered at one time

Normally, a 100-day supply of a drug is the maximum quantity covered at one time. Your plan may also limit the supply for acute drugs to a 34-day supply.

Items that cannot be purchased with the card

There may be some drug expenses that your plan members can't purchase with their drug card.

Refer to the contract/booklet for or a list of these items. The plan member will need to pay the pharmacy for these expenses and submit an **Extended Health Care** Claim.

Lost or stolen cards

If a plan member loses their drug card or has it stolen, go to:

- **mysunlife.ca**
- **my Sun Life Mobile app**
- your Group Service representative

Dental

With Dental care benefits, your plan members are covered for procedures done by:
- a licensed dentist,
- denturist,
- dental hygienist, or
- anaesthetist.

For each dental procedure, Sun Life will cover only up to the reasonable and customary charge for the least expensive alternate procedure, service or treatment consistent with accepted dental practice. The eligible expense can't be more than the fee stated in the appropriate Dental Association Fee Guide.

Getting an estimate

Plan members need to ask their dentist to send us a fee estimate called a predetermination.

This is for treatments over the amount specified in your contract/booklet. We'll let the plan member and their dentist know which expenses, if any, will be covered. This allows the plan member to discuss treatment options with their dentist before the work starts. It also allows them to budget for the expense, if it's not covered by your plan.

Orthodontic claims

Plan members need to submit expenses as they are incurred. If a lump sum is paid, we'll reimburse up to about one-third of the full eligible treatment cost for the initial payment.

Health Spending Account

Please refer to the Health Spending Account Administration Guide if applicable to your plan.

Personal Spending Account

Please refer to the Personal Spending Account Administration Guide if applicable to your plan.

Disability

Short-Term Disability (STD) and Long-Term Disability (LTD) benefits provide your plan members with partial replacement of lost income, during periods of total disability. Plan members must complete the elimination (qualifying) period and qualify for these benefits based on the terms of your contract/booklet.

STD and LTD claim forms come in three parts:
- The **Plan Member Statement**, which must be completed by the plan member,
- The **Attending Physician Statement**, which must be completed by the doctor supervising the plan member's treatment, and
- The **Plan Sponsor Statement**, which must be completed by you, the plan administrator.

For STD, the **Plan Sponsor Statement** comes in two parts:

- The **Plan Sponsor Statement**, which must be completed with each claim submission, and
- The **Job Demands Questionnaire** which must be completed if the absence is expected to be longer than 4 weeks in duration.

Provide the STD and LTD Claim Guides and forms to your plan members to help them through the claim submission process.

To simplify the transition from STD to LTD, we'll supply both you and the plan member with the required forms.

If the Disability Online Tool, on our Plan Sponsor Services (PSS) website, is enabled you'll be able to submit the Plan Sponsor Statement portion of your disability claim online and any other documentation Sun Life has requested. The plan member can complete their form and upload any supporting documentation on **mysulife.ca**. Plan sponsors with proper access can view the status of plan member claims and run reports.

When a plan member returns to work, let us know immediately. Any payment that includes benefits for a period that the plan member was able to work and doesn't qualify, should be returned to Sun Life for final adjustment.

To submit a claim for LTD benefits or for waiver of premiums under the Life and Accidental Death & Dismemberment benefits, ensure the appropriate claim forms are completed and sent to us eight weeks prior to the end of the elimination (qualifying) period specified in your contract.

Notes:

- If a plan member is covered by Sun Life for both LTD and Life benefits, we will assess the waiver of premium claim for the Life benefit at the same time as the LTD claim.
- If a plan member has applied for disability benefits under a government plan (such as workers' compensation), we encourage them to submit a LTD claim to Sun Life, even if they are waiting for a decision under the government plan. We will still assess their LTD and waiver of premium claim.

Life

The following is provided for information purposes only and isn't legal advice. Plan administrators should be careful not to adjudicate claims nor provide advice to claimants on how to settle a dispute. Instead, all questions about a specific claim should be directed to our Group Life Claims Department **group.life.claims@sunlife.com**.

Express Payment Program

The express program applies to Life insurance (basic and optional) for plan members and their dependents, that meet the requirements below. It does not apply to the Accidental Death portion of the Life claim.

- The combined amount of insurance (basic & optional) is $150,000 or less.
- The death occurred in Canada or the United States.
- The beneficiary is at least 18 years old.
- The beneficiary resides in Canada.

- There are no competing claimants nor other beneficiary complications. Examples such as: simultaneous death, criminal offense or if the beneficiary pre-deceased the plan member.
- For optional life:
  - the benefit has been in force for 5 consecutive years, OR
  - proof of good health was not requested at the time of the application.

To process an express payment, we require:

- The Notification of Death form fully completed by the Plan Administrator.
- All beneficiary designations.

To process claims that do not qualify for express payment, we require:

- The Notification of Death form completed by the Plan Administrator.
- All beneficiary designations.
- A Claimant Statement completed by each beneficiary.
- Proof of death in the form of a Physician's Statement or an original or certified copy of a provincial death certificate or a funeral director's statement of death.
- For an Optional Life, we also require:
  - The original approval notice issued by Sun Life confirming approval of the Plan Member's application for Optional Life Insurance, and
  - A completed Physician's Statement if death occurred within 2 years of coverage being medically approved or if the benefit is more than $250,000
- For Accidental Death claims, we also require:
  - Documentation to support the death as being the direct result of an accident, such as a police report or coroner's report and, if available, newspaper clippings that outline the details of the accident.

Important Note: Depending on the circumstances surrounding the Plan Member's death, we may require more information after reviewing the claim.

Partial (advance) payment immediately upon death

Applies to Basic Life insurance only. Where the beneficiary is the estate or a family member (e.g. a spouse) and has an immediate need for funds, a partial claim payment (50% up to $50,000) can be made (within 24 hours) before death claim forms are submitted. This is intended to help the family deal with immediate financial issues such as outstanding debts. The payment will be sent by courier.

The decision to offer a partial (advance) payment is at the plan sponsor's discretion. Advance payments would not be granted if there were any unusual circumstances surrounding the plan member's death.

We require the following information to issue partial (advance) payments:

- Notification of Death form.
- All beneficiary designations.

Estate claims

When the benefit is payable to the plan member's estate, the following applies:

For life insurance amounts	We require
Under $150,000	No additional documentation
$150,000 to $249,999	Notarial copy of Will
$250,000 and above	Notarial copy of Probated Will

If there isn't a Will:

If the deceased plan member was a resident of	We require
Ontario	Notarized copy of the Certificate of Appointment of Estate Trustee without a Will
Québec	Notarized copy of the Notarial Declaration of Heirs
Any other province	Notarized copy of Letters of Administration

More about Wills

The Will must be dated later than the **Enrolment** form (if the Enrolment form designates a different beneficiary than is shown in the Will).

Note:

Plan administrators should avoid giving an opinion on how the Will is to be applied. Once we review a copy of the Will, we'll provide that information. Plan administrators should also validate with the Group Life Claims department if there is a valid change of a beneficiary in the Plan Member's Will.

If the beneficiary is the estate

If the proceeds are payable to the estate, the estate's legal representative should complete the Claimant Statement, if required.

If the beneficiary is a minor

Non-Québec

- If a trustee has been appointed, the trustee needs to complete the Claimant Statement. We'll pay the proceeds to the trustee on behalf of the minor.
- If there is no trustee in place and a Legal Guardian for Property has been appointed for the minor, the legal guardian needs to complete the Claimant Statement and provide documentation showing their appointment.

Québec

- In Québec, the surviving parent is the Sole Tutor for the minor and needs to complete the Claimant Statement on their behalf. We require a certified copy of the birth certificate of the minor that identifies the names of the parents. If there is no surviving parent and an administrator has not been designated, a court-appointed Tutor must make the claim.

Note: Each province has its own legislation concerning payments to a legal guardian on behalf of a minor.

- If a legal guardian hasn't been appointed, payment will be made into the courts or the public trustee in trust for the minor.

How proceeds are paid

We'll issue a cheque in the beneficiary's name and send it to the address provided to us. We will send you a confirmation that we've made the payment.

Note:

- If a beneficiary is interested in exploring other investment options rather than a lump sum cheque, we'll direct them to their nearest Sun Life advisor who can explain the options available to them.

Criminal offence

If the beneficiary is charged with a criminal offence related to the death claim, we can't settle the claim until the criminal charge has been cleared. As a matter of public policy, no one can benefit from a criminal offence.

Beneficiary pre-deceases plan member

If the beneficiary pre-deceases the plan member, we require proof of the beneficiary's death (i.e. funeral director's statement). In this situation, we'll pay out the proceeds to the plan member's estate. If there is more than one beneficiary, the proceeds may be shared among the remaining surviving beneficiaries.* (See **Naming a beneficiary** section.)

*unless there are other pre-printed stipulations indicated on the form.

Simultaneous death

If the beneficiary and the plan member die at the same time (e.g. in the same accident), we try to determine the exact time of death, to determine who died first. If it can't be determined whether the plan member or beneficiary died first, the Insurance Act and Québec Civil Code require us to presume that the beneficiary died first. In that case, the beneficiary's share goes to the plan member's estate, or, if there was more than one beneficiary, the proceeds may be shared among the remaining surviving beneficiaries. (See **Naming a beneficiary** section.)

If the beneficiary died after the plan member, the beneficiary's share goes to the beneficiary's estate.

Living Benefits

Under our Living Benefits Loan Program, a terminally ill plan member with a life expectancy of 24 months or less may apply for a loan of up to 50% of the Basic Life insurance amount, to a maximum of $100,000. If the plan member is within five years of a scheduled reduction of Basic Life insurance, the maximum Living Benefit payable will be 50% of the lowest reduced amount of the Basic Life insurance. The amount of the Living Benefits loan plus interest will be deducted from the proceeds paid to the beneficiaries on the plan member's death.

Notes:

- If a plan member has nominated an irrevocable beneficiary the plan member will require their consent to apply for this benefit.
- If a plan member is within five years of a scheduled termination of coverage, they aren't eligible for the program.
- If the loan is approved you must continue to remit premiums on the full amount of coverage and not the reduced amount.
- Before requesting a Living Benefits loan, contact your Sun Life Service Specialist to discuss the possible financial implications to your contract.

Other claims

Waiver of Life Premium

The Waiver of Life Premium feature under the Life benefit provides ongoing Life coverage for a disabled plan member (and/or covered dependents) without payment of premium during the disability period. This is subject to the terms of the contract that were in effect on the date the plan member became disabled. It includes reductions and terminations.

If another carrier manages the Long-Term Disability benefit, we approve the Waiver of Life Premium when you send proof of the employee's total disability. We require the following information:

- Waiver of premium – Plan Member's Statement
- Waiver of premium – Plan Sponsor's Statement
- A copy of the other carrier's approval letter

Accidental Dismemberment

To make a claim for Accidental Dismemberment, contact us, and we'll send you the required forms. Our claims forms are clear and thorough, and we'll contact the plan member and their physician as appropriate to ensure we have all the information needed to assess a claim. We keep the plan member well-informed of the claim process and decisions.

Critical Illness Insurance

To make a claim for Critical Illness the plan member would call 1-800-669-7921. Critical Illness Insurance does not cover every illness. It is important to review the contract / plan member booklet.

Administration and claim forms

To help you with the administration of your plan, our standard forms have been posted on **mysunlife.ca**.

Step 1 Go to **mysunlife.ca**
Step 2 Select **For plan sponsors**
Step 3 Select **Group Benefits**
Step 4 Select **Forms**

Ordering supplies

Complete the order form to request forms and supplies.

Contacts

As your group benefits partner, we understand your need for quick and easy access to information on every aspect of your plan. Here's how you can contact us, whenever you have a question or concern:

Note: Hours of operation refer to Eastern Standard Time

Group Benefits Administration
Hours of operation: 8:30 AM - 6:30 PM
Phone number 1-866-377-5818

Extended Health Care & Dental Claims
(including HSA and PSA claims)
Hours of operation: 8 AM - 8 PM
Phone number 1-866-246-4153

Disability Claims
Hours of operation: 8:30 AM - 4:30 PM
Phone number 1-866-246-4153

Life and AD&D Claims
Hours of operation: 8:30 AM - 4:30 PM
Phone number 1-800-361-2128

Critical Illness Claims
Hours of operation: 8:30 AM - 4:30 PM
Phone number 1-800-669-7921

Group Medical Underwriting
Hours of operation: 8:30 AM - 4:30 PM
Phone number 1-866-882-0884

Client Relations Representatives team
Dedicated line for advisors and plan sponsors
Phone number 1-866-606-8936

Client Care Centre
Dedicated line for plan members
Phone number 1-800-361-6212

Conversions
(When benefits end or reduce)
Phone number 1-877-893-9893

Group Retirement Services
Phone number 1-833-292-5400

Visit our website: **mysunlife.ca**
Or download **My Sun Life mobile app**

Appendix A — Updates to the guide

The following table summarizes the changes to this version of the guide.

Page	Chapter and/or section	What's changed
4, 7, 16 and 18	Late applicant	If the Extended Health Care coverage is declined, the plan member and the plan member's eligible dependents are still covered for Dental Care.
6	The Enrolment form	Step 6 hyperlink added.
9	Naming a beneficiary	Definitions added for *What is a primary beneficiary* and *What is a contingent beneficiary*.
19	Reductions due to age or retirement	• Title paragraph changed from *Changes due to age or retirement* to *Reductions due to age or retirement*. • Wording added which detail your obligation to contact members when they experience a reduction in Basic or Optional Life. • Reminder added to refer to your contract / booklet for the definition of retirement. • Wording added regarding our Choices Life product.
24	Employer Contributions and Taxable Benefits	Canada.ca and RevenuQuebec.ca hyperlinks updated.
25	Premiums	Title paragraph changed from *How to prepare your premium statement* to *Preparing your monthly premium statement for remittance to Sun Life*.
26	Premiums	Payment options added.

Appendix B — CLHIA Process on Electronic Declarations

CLHIA Process on Electronic Declarations

Introduction

Electronic insurance business practices evolve alongside advances in technology. Canadian life and health insurance companies ("Insurers") and other entities such as third party administrators, employers, and group policyholders/plan sponsors ("Third Parties") involved in the administration of insurance and group benefits on behalf of Insurers must ensure these business practices comply with all applicable laws as well as meet regulatory expectations.

Purpose and Scope

The CLHIA Process on Electronic Declarations ("Process") sets out recommended processes that Insurers and Third Parties acting on behalf of Insurers (collectively "Company" or "Companies") may consider when collecting, using, and retaining declarations electronically. Companies must make their own determination whether they will accept, retain and use declarations electronically and the manner in which they choose to do so.

Each Company's process for collecting, using, and storing the electronic declaration must contain reasonable safeguards to protect the integrity of the electronic declaration.

Recommended Processes

The process should:

1. Be supported by an electronic system designed, adopted by, or otherwise approved by a Company, which is capable of accepting and storing declarations made by an individual policy owner or for group insurance the group life insured (collectively "Insured"). Where a Company chooses to accept more complex declarations electronically, such as declarations that may involve multiple signatories or contingent beneficiaries, the system should be appropriately robust to accommodate these additional requirements. In all cases, the information should be kept secure at all times in accordance with the Company's own requirements for the electronic storage of personally identifying information.

2. Capture the declaration(s) and require the Insured(s) to confirm their intent to make the declaration by way of an electronic signature[1], captured by the system in accordance with the requirements of the applicable electronic commerce legislation.

3. Utilize appropriate technology which captures the declaration, and the Insured's signature in electronic form. When such signature is used it, or the process used to obtain it, should have the following characteristics:

   (i) it is uniquely linked to the Insured;
   (ii) it is capable of identifying the Insured;
   (iii) if subject to the use of authentication credentials or factors, such credentials or factors can be maintained under the Insured's sole control; and
   (iv) it is linked to the declaration or similar document (such as an application or enrolment form) to which it relates in such a manner that any subsequent change of the data is detectable.

4. Provide assurances of the Insured's identity through a verification system allowing:

   a) the identity of the person and their link to the document, to be confirmed by having appropriate authentication safeguards such as the use of:
      i. password log-ins;
      ii. personal verification questions; or
      iii. other logical and operational security measures; and
   b) the document to be identified and, if required, allowing its origin and destination at any given time to be determined.

5. Provide a mechanism for the declaration to be:

   a) accessible to the Insured at the time the declaration is made, so that the Insured can take appropriate action to ensure it is available for subsequent reference;
   b) stored (electronically) so as to be protected against unauthorized access; and
   c) acknowledged by electronic or other means as received by the Company.

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[1] A signature is not specifically required for a declaration made under the laws of Quebec. An electronic declaration must comply with articles 2446 of the *Civil Code of Quebec*, L.Q. 1991, c. 64, and with the *Act to establish a legal framework for information technology*, CQLR c C-1.1.

The characteristics of a process, as described immediately above, provide greater clarity and outline appropriate safeguards where the Insured chooses to utilize electronic means and where the Company chooses to accept electronic declarations and has reliable procedures
in place.

Companies should have their electronic declaration processes reviewed by experienced information security professionals both before implementation and on a regular basis thereafter to ensure they have considered the recommended processes set out above.

Additional Considerations

As technology evolves and the law changes, Companies are responsible for ensuring that their own electronic processes remain up-to-date and compliant with the law. Companies should self-evaluate in this respect as part of the Company's Regulatory Compliance Management System with appropriate approval at a senior level (e.g. Chief Compliance Officer, Chief Risk Officer).

Special consideration should be given to irrevocable beneficiary designations where additional processes may be required.

This document is not a substitute for legal advice. Companies should obtain independent legal advice.

Applicable law takes precedent over any conflict between the provisions of this Process and any applicable law.

December 24, 2019

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