Plan Sponsor Services

SunAdvantage Administration guide

Use this guide for client-administered group plans if you use our Plan Sponsor Services website for online benefits administration.

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

Life's brighter under the sun

Sun Life Financial

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Introduction to Plan Sponsor Services

Tips:

To reset your Password, select Forgot my Password when you are on the Plan Sponsor Services sign on page.

Do not share your Access ID or Password with anyone. They are key elements of our Web security to protect you and your plan members' information.

Welcome to Sun Life Financial's Plan Sponsor Services. Our customer-driven Web-based tool that lets you handle the most fundamental and the most complex aspects of your group benefits program. Plan Sponsor Services makes record keeping quick and easy, and puts information at your fingertips – when you need it. We also provide a Health Spending Account Administration Guide, if applicable to your plan.

With our Plan Sponsor Services website, you can:

- Enrol plan members, update their records.
- Terminate and/or reinstate their coverage.
- Generate and print coverage summaries for plan members.
- View details of your benefit plan's coverage and plan set-up.
- Download and print a wide range of standard forms for benefits administration.
- View and print a monthly premium statement.

To use our Plan Sponsor Services website, you will need:

- Windows 2000 or higher.
- An Internet connection with adequate performance (56 KB modem or higher).
- 128 bit encryption.
- Microsoft Adobe Acrobat Reader 7.0 or higher.
- Microsoft Internet Explorer, version 8.0 or higher, or Mozilla Firefox, version 2 or higher.
- A plan sponsor Access ID and Password.
- This Administration Guide, your group benefits contract and your Benefit Booklet.

Your Access ID and Password

Security is critical when you're using the Internet to administer your benefits plan. Our password-protected website, strong encryption, firewalls and a high level of physical security at the server site are some of the ways we protect your data and keep it confidential.

Your Customer Service Administrator will contact you to provide you with your Plan Sponsor Access ID and Password.

When you receive your Plan Sponsor Access ID and Password, go to **www.sunlife.ca/sponsor**, enter them in the appropriate fields and select **Submit**.

For security reasons – the first time you use the website you will be asked to change your Password immediately, enter your date of birth, choose a verification question from the list provided and enter an answer that only you know. If you forget or lose your Password in the future, you can reset it online by selecting **Forgot your Access ID?**, enter the date of birth you previously provided, and correctly answer the identity verification question. This information will allow the system to validate you as a registered user.

You should also submit a valid, current e-mail address if you have not already done so. Once a valid e-mail address is entered you will receive a confirmation e-mail from Sun Life. Please follow the instructions in that e-mail to complete the validation process.

Quick Reference Guide

This document provides your members with a summary of the most commonly referenced benefit information and is conveniently included in each Welcome and Enrolment envelope. Members can view their full benefit booklet by registering online at **www.mysunlife.ca**. If required, a hard copy is available on request.

As a plan administrator of Plan Sponsor Services (PSS) you maintain your plan member records directly on our online administration system, and we prepare your monthly premium bill based on this information. This guide is designed to help you. It describes the procedures to be followed in the day-to-day administration of your plan and should be used in conjunction with your group benefits contract and Benefit Booklet.

A key part of your role is to update all necessary plan member information on a timely basis so we can pay claims and prepare your monthly premium bill. All plan member enrolment forms and changes, which include beneficiary designations, are kept at your location.

Although this guide is designed to generally reflect your benefit plan, you may find references to benefits or provisions that don't apply to your plan. Please ignore those references.

Note:
This guide does not override the terms and provisions of your group benefits contract. You are responsible for administering your plan in accordance with the terms outlined in your contract.

When corresponding with us you should always include your company name and contract number. If you are writing regarding a plan member, be sure to include the plan member's full name and identification number.

Protecting members' privacy

We are committed to protecting personal information about your members. Our global privacy commitment outlines a common and consistent set of principles that all of our Sun Life Financial companies follow. All of our representatives and employees are required to sign and comply with our annual Code of Business Conduct, which includes privacy requirements.

Our privacy policy and code for Canada include obligations relating to appropriate collection, use and disclosure of personal information. Confidential plan member medical information is not released to plan sponsors, doctors, members' workplace medical or health centre staff, legal representatives, etc., without consent of the plan member, and even then, only in certain circumstances. As administrator of your benefits plan, you may need to handle documentation that contains personal information about your employees and their dependents. We rely on you to maintain that same level of respect for the privacy of plan member information in the course of your day-to-day administration activities.

Our privacy policy and code for our Canadian operations can be found on our website at **www.sunlife.ca**.

Getting started

Once you enter your plan sponsor Access ID and password, the **Plan Sponsor Services** home page appears. From here you can:

- Select an application.
- Read messages about topics you need to be aware of.
- Select links to useful information.

Tips:

- **Select Group Benefits** from the menu at any time to return to the Welcome page.

  Need help? Refer to your administration guide or our **Frequently asked questions** for the information you need.

  When you are finished your session, select **Sign Out.** Signing out helps to ensure your data is protected.

- Keep all member information filed in a safe place.

  You can process multiple changes to a member record on the same business day if all changes have the same effective date.

  A Coverage Summary form is to be provided to the member any time a change of information occurs.

Select **Group Benefits Administration** to access online administration.

From the Welcome to Group Benefits Administration page, you can access a variety of member and administration options. The options available may vary depending on your administrator access and plan design.

Navigation bar	You can access the full range of options for administering your benefits from the navigation bar along the top of the page. Select **Members, Billing & Reports or Guides & Information** to display drop-down menus.
Group Benefits	Select **Group Benefits** at any time to return to the Group Benefits Administration Welcome page.
Help	Get information on how to switch your language on the website, change your profile and other topics.
Contact us	Find the right phone number to call to get answers to your questions.
Profile	Select this option if you need to change your password, your verification information, or your e-mail address. (Your e-mail address is required before you can reset your password online.)
Sign Out	Select this button to sign out and protect your data.
Quick Links	Easy access to popular features.
View a member	Search for members by name, ID or by using a "wildcard" (a handy feature when you have limited information with which to search).
Members	Quick access to most commonly used member features
Guides & Information	Quick access to reference resources.

Member infomation

You'll find the functions you need to manage your plan member information in the Members section:

- View a member.
- Add a member.
- Update a member.
- Reinstate a member.
- Terminate a member.
- Special requests.
- Update many salaries.

With Inquiry access you can view member information and access special requests.

About effective dates

Most member changes you process on our Plan Sponsor Services website will require you to enter an effective date of change (the date as of which you want the change to apply)

Tips	
Adding a new plan member	**Member information** • Enter the plan member's hire date and the system will apply the waiting period, if applicable, to calculate the effective date. **Benefit information** • The system will set the benefit effective dates. • If there are waiting periods, the benefit effective dates will be set to the first date after the waiting period has been satisfied.
Updating a plan member	**Member information** • The effective date is the date the event occurred, e.g. birth, adoption, marriage, etc. **Benefit information** • The effective dates cannot be earlier than the benefit effective dates, or the member's hire date.
Reinstating a plan member	**Member information** • The effective date is the date the member returns to work. Benefit information • If there are no waiting periods, the effective date is the date the member returns to work. • If there are waiting periods, the effective date is the first date after the waiting period has been satisfied.
Terminating a plan member	**Member information** • The effective date is the date the member's coverage terminates.

Types of plans and effective dates

Which type of benefit plan do you have? It's important to know since some administrative details such as effective dates are based on the type of plan you have.

Please refer to the participation level in your contract to ensure all eligible plan members are enrolled according to your contract terms.

Determining effective dates

If your contract includes a waiting period, members must satisfy that waiting period before their coverage takes effect.

Plan members must be actively at work on the date coverage would normally begin in order for coverage to become effective.

Participation Level of 100% (mandatory benefit plan)

Benefits take effect on the day after the member satisfies the waiting period and other eligibility requirements.

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

Ensure enrolments are processed in a timely manner. The coverage effective date is determined by the following:

If you 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 signed
• More than 31 days after the date the plan member becomes eligible. The member is considered a late applicant. The member and eligible dependents must complete a Statement of Health form to verify proof of good health.	• The date the Health Statement is approved. There may be a restricted maximum for Dental). We will notify you in writing whether the application is approved.

About 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 member and dependent coverage (unless the members and dependents have coverage elsewhere, e.g. spouse's plan).

Combined mandatory and non-mandatory plans

The benefits effective date will be based on the rules above for each type of plan.

Note:

If your contract contains health, accident or disability benefits and you have a place of business in Québec, it 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 mandatory for both the member and dependent coverage(unless the member and dependents have coverage elsewhere, eg spouse's plan).

For any coverage requiring proof of good health (see Enrolling in the plan section)

Benefits become effective on the later of the date the member is eligible or the date the Health Statement is approved.

When a member refuses coverage

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

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

Non-mandatory plan: All refusals by plan members must be documented in writing for future reference. Make sure the member completes and signs a Refusal for Group Coverage form as proof that coverage was offered to the plan member and was declined.

Reinstating a former plan member

- If your contract contains re-employment conditions (e.g. six months), the waiting period is not required if a plan member is re-employed within the number of months indicated in the contract.
- Coverage should be reinstated on the date of re-employment.
- If re-employment is outside the number of months specified in your contract, the member will need to satisfy the waiting period set out in your contract from the date of re-employment.
- The reinstated plan member will have the same level of benefits as prior to termination.

The reinstatement rules follow the mandatory or non-mandatory plan rules outlined earlier.

If your plan has optional benefits

Your plan may include optional benefits such as Optional Life and Optional Accidental Death & Dismemberment. Some optional benefits require proof of good health and a Health Statementmust be completed. Coverage becomes effective on the later of the date the member or dependents are eligible or the date the Health Statement is approved. (See your group Benefit Booklet for details).

Enrolling in the plan

Notes:

When plan member data is added to our administration system, it is transferred overnight to our claims system and then to our Pay-Direct drug system the following night. Any claims processed during this period will not reflect the new data.

It's a good practice to enrol plan members in the benefits plan as soon as they are hired, even though a waiting period may need to be satisfied before being eligible to receive benefits.

The Enrolment Guide Envelope

Step 1 Complete the first section of the Enrolment form included at the back of the Enrolment Guide for each plan member.

Step 2 Provide the plan member the Enrolment Guide Envelope and have the plan member complete the remaining sections and return to you.

Step 3 Review the form to ensure it is fully completed and signed by the plan member.

Step 4 Enter the Plan Member on the system through the Plan Sponsor Services site (www.sunlife.ca/sponsor). A coverage summary will automatically be generated which you should print and give to the member.

Step 5 File in your member records file.

Please note the Enrolment Guide provides the member a drug card (if applicable to your group plan) as well as important information on how to access benefit coverage on line. Included in the envelope is a Quick Reference Guide for a general summary of the benefit coverage. The Benefit Booklet with full benefit details can be found on our website at **www.mysunlife.ca**. If a member requires additional cards for their use the member can sign into our website at **www.mysunlife.ca** to print extra copies. As well printing a drug card for a plan member is a feature available to you through the Plan Sponsor Services site.

Please note: if a member or their dependents are presently covered under another group plan for Extended Health Care and/or Dental and has refused benefits under this plan, certain sections of this guide will not apply, such as the drug card (if applicable to your group plan).

More on the Enrolment form

Detailed dependent information is entered on our claims system for validating claims eligibility The spouse details and children's details section of the Enrolment form must also be fully completed.

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

The beneficiary nomination must be signed and dated in ink by the plan member, as this is a legal document. (See Naming a beneficiary section.)

Notes:

- The Coverage Summary form will indicate if a Health Statement requires completion for full coverage amounts to be effective. Any benefit with such requirement will be noted with an asterisk (*).
- If a plan member was previously approved for excess coverage (over the proof of good health level) the Health Statement is only required if a salary change increases coverage by greater than 25 per cent of existing coverage, or $25,000 for Life or $500 per month for Long-Term Disability.

When proof of good health (Health Statement) is required

A Health Statement is required when:

- A member is a late applicant (see Determining effective dates).
- A member who originally refused benefits in a non-mandatory plan is now applying for coverage.
- A member is applying for Optional Life or other voluntary benefits.
- A member's Life or Long-Term Disability amount exceeds the proof of good health). (Your Quick Reference Guide will indicate this information).
- First-time coverage exceeding the proof of good health and thereafter if there is:
- An increase in the Life benefit of 25 per cent of existing coverage or $25,000, whichever is greater,
- An increase in the Long Term Disability benefit of at least 25 per cent of existing coverage or $500 per month, whichever is greater.

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 is highly confidential. Advise the plan member to send the completed form directly to us. Mailing instructions are provided on the form.

Step 4 We will notify you and the plan member of our decision.

Step 5 If approved Sun Life will update the approved coverage directly on our administration system.

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 or remit premium for the coverage under review. If approved, the coverage will be effective on the date of approval and premiums charged accordingly.

If the application is approved: A confidential letter will be sent to the plan member advising of our decision.

If the application is declined: A confidential letter will be sent to the plan member advising of our decision and stating the reason for decline.

If additional information is required: A confidential letter will be sent to the plan member requesting the required information. If the member does not provide the requested information, we will advise the member that the file will be closed.

We will notify you in writing whether the application is approved.

Naming a beneficiary

Notes:

- When a member nominates their beneficiary(s), you should ensure that they are not changing a previous nomination of an irrevocable beneficiary. (Please see further details on irrevocable beneficiaries below.)
- Plan members cannot name a bank or financial institution as their beneficiary for purposes of providing collateral for a loan.

If your group contract includes Life benefits, the member should designate a beneficiary on their Enrolment form stating the beneficiary's full name and relationship to the member.

The beneficiary nomination is a legal document and therefore the beneficiary section must be completed, signed and dated in ink by the member. The member must initial any changes or alterations to the nomination, no matter how small. Correction fluid cannot be accepted.

Revocable and irrevocable beneficiaries

Revocable beneficiary means that the life insured (plan member) is free to change the beneficiary designation at any time. A beneficiary is assumed to be revocable (unless specifically designated as irrevocable) in all provinces except in Québec.

Irrevocable beneficiary means the member cannot change the designation without meeting specific requirements. 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 specified as revocable. If the revocable box on the Enrolment form or Beneficiary Nomination form is not checked off, the designation is irrevocable.
- **Irrevocable at the member's request** — If a member wishes to voluntarily designate a beneficiary as irrevocable, they simply write the word "irrevocable" on the beneficiary nomination itself; for example, "John Doe, Spouse, Irrevocable".
- **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 document issued by the court should be kept with the beneficiary nomination for future reference.

Changing a beneficiary designation

If the beneficiary designation is revocable: A Beneficiary Nomination form must be completed, dated and signed by the member.

If the beneficiary designation is irrevocable: A Beneficiary Nomination form must be completed, dated and signed by the member. In order for a member to change an irrevocable beneficiary or to change the current beneficiary designation from irrevocable to revocable, the member must also submit one of the following documents:

- Consent by Beneficiary form, signed by the irrevocable beneficiary, revoking their rights
- Final Decree of Divorce, if the irrevocable beneficiary is the member's spouse (Québec only)
- Proof of death of the irrevocable beneficiary

More about beneficiary designations

Event	Additional information
If your plan has Optional Life benefits	The member may designate separate beneficiaries for Basic Employee Life, Optional Life and Spouse Optional Life. The member needs to complete each of the applicable sections of the Enrolment form or Beneficiary Nomination form. This is true evenif the member wishes to designate the same beneficiary for basic and optional benefits.
Designating one beneficiary	To designate one beneficiary, the member must complete the name and relationship of the beneficiary and indicate 100 per cent on the percentage area of the form.
Designating more than one beneficiary	To designate more than one beneficiary, the member must complete the name and relationship and percentage on the form for each beneficiary. The total of the designated percentages must equal 100 per cent.
Appointing a contingent beneficiary	To appoint a contingent beneficiary, the member should complete the Contingent Beneficiary section of the 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	To designate a minor child, the member must designate a trustee in all provinces except Quebec. In Quebec, a trustee is not legally required, but if there is one, a trust must be established by a separate trust agreement, or in a Will.
Designating an estate	A member designating the estate as beneficiary should 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 an individual beneficiary may be protected from creditors. • Probate costs vary from province to province and are based on the total value of the estate. These costs are not incurred if proceeds are payable to an individual beneficiary.
When no beneficiary has been designated	Proceeds will be paid to the member's estate. A properly constituted and current Will should be submitted with any claim to avoid delays in processing.

Other things to consider when more than one beneficiary has been designated:

Beneficiary dies before the member, and there is no disposition of the share for the deceased beneficiary	The share is payable: a) to the surviving beneficiary, or b) if there is more than one beneficiary, to the surviving beneficiaries in equal shares or c) if there is no surviving beneficiary to the member's estate

It is a good idea for plan members to consult a lawyer for direction before requesting a complex beneficiary arrangement or if they need advice because of their personal circumstances.

Beneficiaries in Quebec

The following table, prepared by the Canadian Life and Health Insurance Association Inc. (CLHIA), will help you to answer questions on beneficiary designations for Québec members. This chart will help you understand when a beneficiary change is allowed.

Current beneficiary designation	Can be changed to
Spouse designated on or after 20/10/76 if indicated as revocable on the enrolment form	Any beneficiary
Spouse designated on or after 20/10/76 – stipulates that designation is irrevocable, OR does not stipulate that it is revocable	Cannot be changed unless: • A waiver was signed • Divorce was granted on or after 20/10/76 and before 1/12/82 terminating the spouse's rights, or • Divorce was granted on or after 1/12/82
Husband designated on or after 1/7/70 but before 20/10/76 with or without revocability stipulation	To designate more than one beneficiary, the member must complete the name and relationship and percentage on the form for each beneficiary. The total of the designated percentages must equal 100 per cent.
Husband designated on or after 1/7/70 but before 20/10/76 with irrevocability stipulation	Cannot be changed unless: • A waiver was signed • Divorce granted on or after 20/10/76 and before 1/12/82 terminating the husband's rights, or • Divorce 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 on or after 20/10/76 but before 1/12/82	Child until 20/10/77; otherwise wife's designation is irrevocable except if she waived her right or if divorce terminated her rights

Maintaining plan member records

Notes:

When plan member data is added to our administration system, it is transferred to our claims system overnight and to our Pay-Direct Drug system the following night. If claims are processed during the transfer this period, they will not reflect the new member data.

- Once updates to the plan member record have been made, an updated coverage summary will automatically be generated which can be printed and distributed to the plan member.
- A plan member must be actively at work on the effective date of a salary change.

It is very important that plan member information is kept up-to-date at all times. Through the "update a member: functionality you should enter changes as soon as you are notified to ensure there is no disruption to claim payments and that your billing statements are accurately calculated.

Recording plan member changes

The effective date must be recorded for all changes affecting a 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.

Outlined below are general guidelines that you'll need to keep in mind for some specific plan member changes.

Change from single to family status

When a plan member enrols in the benefit plan with single coverage and requests a change to family status, the rules around mandatory and non-mandatory plans apply:

- **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 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*
• Within 31 days of the event	• The date of the event*
• More than 31 days after the date of the event, the plan member's dependents are late applicants and must complete a Health Statementto verify proof of good health	• The date the Health Statement is approved, and we will notify you in writing of the approval. (There may be a restricted maximum for Dental)

* A Health Statement is required for any existing dependent not already covered.

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

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

Notes:

- When plan member data is added to our administration system, it is transferred to our claims system overnight and to our Pay-Direct Drug system the following night. If claims are processed during the transfer this period, they will not reflect the new member data.
- Once updates to the plan member record have been made, an updated coverage summary will automatically be generated which can be printed and distributed to the plan member.
- A plan member must be actively at work on the effective date of a salary change.

Updating student information

Coverage for a dependent child terminates at the lower age limit specified in your contract unless the dependent child meets the criteria to continue coverage as an overage student.

You must notify us if coverage for a dependent child is to continue past the lower age limit. You can send this information any time up to one year prior to the date the child reaches the lower age limit.

Once our system is updated to reflect that a dependent child is an overage student, you'll need to inform us if this status changes.

We recommend that you contact your members annually to validate the accuracy of their dependent coverage, especially with regard to overage students.

For claims paid on a reimbursement basis, the member must declare that the dependent child is an overage student each time a claim is submitted for that dependent. If the student indicator is not noted on the claim form, the claim will be declined.

Adding coverage that was initially refused due to comparable coverage

Event	Mandatory plan	Non-mandatory plan
Other coverage ends (e.g. spouse's plan)	Coverage start date should be the date the other coverage ends	• Coverage start date should be the day after the other coverage ends. The plan member must request coverage within 31 days of the other coverage ending. • 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 eligible dependents must complete a Health Statement to verify proof of good health. There may be a restricted maximum for Dental.
Other coverage doesn't end, but member requests coverage after initially refusing	Coverage start date should be the original effective date	The plan member is considered a late applicant. The member and eligible dependents must complete a Health Statement to verify proof of good health. There may be a restricted maximum for Dental.

Terminating coverage

You need to update the PSS system with the coverage termination date when a member's employment ends or if the member is no longer actively working. Your contract specifies when coverage terminates.

You are also responsible for notifying eligible plan members of their right to apply to convert their Life coverage to an individual insurance policy. (See the **Purchasing individual insurance when benefits end or reduce** section.)

Changes due to age or retirement

Coverage may reduce or terminate at a certain age or at retirement. Dates may vary from one benefit to another.

The member and spouse are eligible to apply to convert their Life coverage to an individual policy when coverage reduces or terminates. (See the Purchasing Individual Insurance when benefits end or reduce section.)

Changing a beneficiary designation

A Beneficiary Nomination form needs to be completed, dated and signed by the plan member, entered in the PSS system and filed with the original Enrolment form in your member records file. (See the Naming a Beneficiary section.)

Plan members who are approved for disability

Sun Life will update the system to reflect the premium waiver for the appropriate benefits when a member is receiving Long-Term Disability benefits or when a Waiver of Life Premium has been approved.

Maternity/parental leave

All coverage should be continued while a member is on maternity or parental leave. You need to make arrangements to collect any premiums required from the members. However, if there are optional benefits that can be elected separately under the plan (e.g. Optional Life), the member may elect to cancel the optional benefits during the leave period.

Continuing coverage during a leave

- You do not need to notify us if all coverage is continuing for the province's legislated maternity/parental leave period.
- If optional benefits are terminating, the cancellation of the optional benefit will be treated as a refusal, and a Health Statement will be required in order to re-elect the benefit.
- Refer to the Administrative exceptions section if coverage is being requested beyond the province's legislated maternity/parental leave period. For plans where members contribute to premiums and do not want to pay their portion of the premium during the leave, members cannot choose to continue some benefits and cancel others. All benefits must be terminated.

Note:

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 mandatory for both member and dependent coverage. (unless the members and dependents have coverage elsewhere, e.g. spouse's plan).

If all coverage was terminated during the leave and the return to work is within the province's legislated maternity/parental leave period:

- Benefits previously in force should be reinstated immediately upon return to work. The waiting period should not be reapplied.
- Reinstatement of coverage follows the mandatory/non-mandatory plan rules outlined earlier. (See the Types of plans and effective dates section.)

If a plan member dies

If a plan member dies, provide us with the date of death. We will continue benefits for the survivors as per the terms of your contract, if provided under your plan. Advise the survivors to continue submitting claims under the member's contract number and ID. We will automatically terminate the coverage at the end of the survivor period.

The continuation of benefits for survivors does not apply to the spouse's Optional Life, Optional Accidental Death & Dismemberment or any Critical Illness coverage.

Follow the instructions in the Submitting claims section to submit the Life claim.

Adding or changing Optional Life benefits

If your plan has optional benefits, a member may elect to add them after they have initially enrolled, or may elect to increase the amount of optional coverage initially selected.

- The member must complete the optional benefits section of the Enrolment form. A Health Statement must also be completed. (See Submitting a Health Statement).
- If electing optional benefits for the first time, make sure that the member nominates a beneficiary for the optional coverage.

Administrative reports

Here you'll find our standard suite of administrative reports. Each of these reports is available to you at any time. Just schedule the reports whenever you need them. Note: Plan member updates are not reflected on reports such as Member Listings until the day after they are processed.

Available administrative reports

- **Coverage Summaries** provide a member's current address, benefit details, dependent details, beneficiary information and will indicate if a Health Statement requires completion for full coverage amounts to be covered. A copy of the Coverage Summary is to be provided to the member any time a change of information occurs.
- **Member Change** Forms are pre-filled with member information on the left hand side. The member can complete the right hand side with new or changed information.
- **Member Coverage** Listing lists all your members' current coverage information, split by location. These reports also provide total number of lives and volume*, by benefit. (*Volume means the member's amount of coverage as outlined in the benefit details section of the Benefit Booklet. If the premium rate is expressed as a percentage of payroll then the volume is the member's eligible payroll amount, not the amount of coverage.)
- **List of Employees with Pending Benefits** lists all plan members that have pending benefits. You should review this report regularly and remind your members to submit a Health Statement. To access the form, select **Forms** from the **Guides & Information** menu.
- **Overage Dependent Listing** lists all the dependents that are over the age limit for your plan. If you have received confirmation that these dependents are students, you need to update their dependent status on the **Update a member** screen. If the overage dependent is not a student, terminate their record on the **Update a member** screen.

Purchasing individual insurance when benefits end or reduce

When group Life benefits end or reduce, the plan member and/or their spouse can apply to continue the terminated/reduced group Life amount through:

- A Sun Life Financial individual policy - application must be made within 31 days of the group coverage ending/reducing. No proof of good health is required. The conversion provision is subject to certain conditions that are outlined in your contract.
- **My Life CHOICE term insurance - application must be made within 31 days of the group coverage ending/reducing. Depending on the amount applied for, the member and/or their spouse may or may not be asked health questions. There are a number of rules and conditionsthat apply to this offering.**

The plan member also has the option to purchase our My Health CHOICE health and dental coverage without proof of good health, if they apply for it within 60 days from the date their health and dental coverage terminates.

If the Critical Illness coverage ends, the plan member and/or their spouse may continue with their coverage under a group Critical Illness plan that is offered by Sun Life Assurance Company of Canada at that time, without having to provide proof of good health. The written request must be submitted to us within 31 days from the date the coverage ends. The portability provision is subject to certain conditions that are outlined in the contract.

You are responsible for notifying eligible plan members of the right to apply to convert, including:

- Informing the plan member of the 31-day period to convert their and/or their spouse's Life insurance, or to apply for My Life CHOICE coverage
- Informing the plan member of the 31-day period to apply for their and/or their spouse's portability provisions for Critical Illness, and
- Informing the plan member of the 60-day period to purchase My Health CHOICE for themselves and or their spouse.

It is the responsibility of the plan member to notify their spouse of the right to continue any spousal coverage.

You also need to complete the Insurance options for plan members on termination of group benefits form, verifying the plan member's and/or their spouse's eligibility.

Please be sure to notify the plan member about these privileges as soon as possible following the termination or reduction in benefits so they avoid missing the deadline.

Special Requests (administrative exceptions)

Our website is designed to make benefits administration as easy as possible. There are however some transactions that you need to submit to Sun Life Financial for processing since they need special attention. Send us the details for these transactions through the Special requests feature on the Members menu. We'll process the changes for you and respond to you within 48 hours to confirm that the changes have been made.

Waiver of waiting period

Requests to waive waiting periods should be completed through the Special Request feature on the PSS site. We will consider the request to waive the waiting period and notify you of our decision.

Other administrative exceptions

Step 1 For all other admin exception requests, provide all relevant information about the request in the Special Request feature on the PSS site

Step 2 We will advise you of our decision. If approved, we will outline the terms of the approval.

- **Coverage for temporary work stoppages** such as layoffs, strikes, maternity/parental leave, leave of absence and sabbatical. Approval is required if the covered period exceeds the greater of one month or the time limit outlined in the group benefits contract, or, for maternity/parental leaves, the longer of the province's legislated maternity/parental leave period or the limit outlined in the contract.
- Coverage during a strike or lockout.
- **Coverage for permanent work stoppages** such as permanent layoff and severance beyond the terms of the contract.
- **Request for out-of-country coverage extension**. Approval is required to cover a member or dependent who will be traveling or residing outside the country for business, pleasure or attending school beyond the time limits outlined in the group benefits contract.

When are employer-paid premiums taxable benefits?

The information below is not intended to provide tax advice. **We recommend that you consult a tax advisor to determine when plan-sponsor paid premiums should be reported as a taxable benefit to members.**

The following overview applies to situations where the plan sponsor is an employer and plan members are employees.

Premiums for some employer- paid group benefits must be included in employees' income as taxable benefits for tax reporting, depending on the province where they live or work. The value of these taxable benefits must be reflected when you report employees' income during the year and when you issue their tax slips.

The information in the table summarizes when group benefits, insured by an insurance contract, are taxable benefits to employees.

Event	Mandatory plan	Non-mandatory plan
Employer paid premiums that are taxable benefits	Employer-paid premiums and related sales tax on group life insurance are taxable benefits for current and former employees.	Employer-paid premiums and sales tax for group life insurance; private health services plan benefits (such as medical, dental, health spending account); and other group insurance, such as AD&D and Critical Illness are taxable benefits for current, past and future employees who live or work in Quebec.
Employer paid premiums that are not taxable	Employer-paid premiums for (AD&D), private health services plan benefits (such as medical, dental and health spending account) , disability benefits and Critical Illness* are not considered taxable benefits.	Employer-paid premiums for disability benefits are not considered a taxable benefit. Employer-paid premiums paid for private health services plan benefits (such as medical, dental, health spending account) for the benefit of the surviving spouse of a deceased employee are not considered taxable benefits.
Taxable benefit calculation	In general, the calculation for the taxable benefit is: Total premiums and related sales tax LESS Premiums and related taxes paid by the employee	In general, the calculation for the taxable benefit is: Total premiums and related sales tax paid for the employee's coverage (e.g. individual, single-parent or family coverage) and benefits (e.g. medical, hospital or dental) LESS Premiums and related taxes paid by the employee and premium refunds (dividend, returns or refunds) received during the year with respect to the employee's coverage and benefits

*Currently the taxability of critical illness insurance is uncertain; however, it appears that when the definition of accident and sickness is met and there is no guaranteed premium refund provision, critical illness would not be considered a taxable benefit.

Both the Canada Revenue Agency (CRA) and Revenu Québec publish taxable benefit guidelines each year outlining what must be included as income as defined under their respective income tax acts.

- You can find the CRA guidelines at **www.cra-arc.gc.ca**
- You can find the Revenu Québec guidelines at **www.revenu.gouv.qc.ca/eng/ministere/index.asp**

Premiums

You will find your monthly premium statement under the "billing and reports section". Each month you are required to print your premium statement from the web site. You will be notified by e-mail when the monthly bill has been posted to the site, provided we have your validated e-mail address.

Premiums are due on the first of the month. They 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 payment is received.

Pre-Authorized Debit (PAD)

For your convenience we also offer pre-authorized debit (PAD) as an option. If you are interested in this payment method, complete the pre-authorized debit form posted on our website (see Guides and Information section under the forms header).

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

Guides & information

This section will provide you with helpful information and instructions for administering your benefits plan.

What's new

Here you'll find information about new developments on our Plan Sponsor Services website and more. Check this section periodically to read about what's new.

Your administration guide

The online Administration Guide contains information about the administrative processes for your reference.

Forms

Here you'll find the forms you need to manage your plan. If you can't find the forms you're looking for or need more forms, please contact your Customer Service Administrator.

Plan setup

Get details about your plan design at your fingertips.

Provincial health plans

Find out about the public health plans available across Canada. This section provides you with a detailed description of what each provincial plan covers.

Submitting claims

At Sun Life Financial Group Benefits, we want claims submission to be easy, so we offer plan members and providers a number of ways to submit claims.

Internet and electronic

Extended Health Care, Dental Care and Health Spending Account claims: If you are set up for e-claims, plan members can submit certain Extended Health Care, Dental Care and Health Spending Account claims online using our convenient, password-protected website at **www.mysunlife.ca.**

Dental: Dentists can submit claims electronically on behalf of their patients using Electronic Data Interchange (EDI). This means plan members don't have to fill out claim forms after visiting the dentist, and claims are received and processed faster – often within seconds.

Drug: Pharmacies can submit prescription drug claims electronically for customers who have Pay-Direct Drug and Deferred Drug plans. Instant claims processing means minimal work for the member. Pay-Direct drug cardholders only pay the amount your plan doesn't cover (such as the deductible, or amounts over the plan limits), and while Deferred Drug plan members must pay for their prescription drugs at the pharmacy, their claims are submitted immediately and processed faster.

my Sun Life Mobile: Plan members with smartphones who download the my Sun Life Mobile app can submit and track benefits claims on the go. They can even use their smartphone as a drug card.

TELUS Health eClaims: Allows plan members to have their physiotherapists, chiropractors and visioncare providers submit their claims electronically to Sun Life on their behalf. This secure online option will result in plan members receiving their benefits payments faster and will help decrease the risk of loss from fraud due to Sun Life's anti-fraud technology.

If they lose their card or need extra copies for family members, plan members can print drug cards from our website at **www.mysunlife.ca**.

Paper – Mail

Plan members can mail completed Extended Health Care , Dental Care and Health Spending Account claim forms, along with their original receipts, to the claim office listed on the back of the claim form. Personalized claim forms can be downloaded from our website at **www.mysunlife.ca**. Claims are assessed based on the information that you or your plan members send to us, so it is important to ensure that our records are up to date and that all claim forms are fully completed and received within the time limits specified in your contract.

Coordinating benefits with other plans

Plan members can coordinate their medical and dental expenses with other plans to maximize their benefits. The insurance industry has guidelines that all insurers use to determine which plan the claim should be sent to first. Here are the guidelines:

Claims for Plan member's 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. the member's birthday is in June and the spouse's birthday is in March, the spouse's plan pays before the 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 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 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 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 member should note on the claim form that they do not have custody of the child).

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

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.

To claim the balance that was unpaid from the first plan, the member needs to send us the original claim statement received from that plan along with copies of the receipts or the initial Dental Claim Form. Receipts should include the name of the patient, the nature of the treatment or medical product, the name of the prescribing doctor, the date and the amount charged.

If both spouses' benefit plans are administered by Sun Life Financial: The member can direct us to pay from both benefit plans as part of the same claim process. The member completes the appropriate section of the Extended Health Care and/or Dental claim form, showing the second benefit plan's contract number and the spouse's member ID number. The spouse must sign the claim form to authorize us to process the claim under their plan. If a dental accident occurs, health plans with dental accident coverage will pay benefits before the dental plan.

Note:

Drug cards can only be used within Canada. If a member needs to purchase a prescription while travelling, they should submit an Extended Health Care Claim on their return to Canada. We will assess the claim and convert the eligible expense amount to Canadian dollars.

Extended Health Care

Extended Health Care benefits cover necessary medical expenses that are not covered by provincial hospital and medical plans. (For details, see your Benefit Booklet.) For all medical expenses other than drug expenses payable under a drug card program, plan members must submit a completed Extended Health Care Claim through methods outlined above and in the My Coverage Guide. Claims for hospital expenses are normally submitted directly to us by the hospital, and we pay the hospital directly. The member receives a claim statement from us showing what was claimed and paid. Note: Members should check their claim statement to ensure they actually received the services being claimed. If the plan member is claiming expenses for a spouse or child, see the Coordinating benefits with other plans section.

Out-of-province medical expenses

To make a claim for emergency medical expenses while traveling out-of-province, the plan member must contact Europ Assistance USA, Inc., our travel assistance service provider, immediately and follow the instructions in their Travel Benefit pamphlet. (These pamphlets are available directly from our website at **www.mysunlife.ca**. To claim non-emergency, out-of-province medical expenses, members should complete an Extended Health Care Claim through methods outlined above and in the My Coverage Guide.

Pay-Direct Drug plans

A Pay-Direct drug card helps to simplify the prescription drug claim process by eliminating the use of claim forms as well as reducing out-of-pocket expenses for plan members.

A drug card is provided in the My Coverage Guide. If a member requires additional cards for their use the member can sign into our website at **www.mysunlife.ca** to print extra copies. As well printing a drug card for a plan member is a feature available to you through the Plan Sponsor Services site. Drug cards are used to purchase prescription drugs only. They are accepted at most drug stores across Canada. Plan members simply show their drug card to the pharmacist, and provided the drug is eligible, will pay only the amount not covered by the plan (e.g. the deductible or amounts over the plan limits).

When the drug card does not work at the pharmacy
These are some of the most common reasons that drug cards are declined:

Issue	Solution
Incorrect date of birth is entered	• When submitting a prescription, the pharmacist will ask for the patient's date of birth. The pharmacist keys this information in when sending the claim electronically. If the date of birth the pharmacist submits does not match the date of birth on our system, the claim will be declined. • Plan members should ask the pharmacist to check if the correct date of birth was entered. If it was and the claim is still rejected, check to see what date of birth is recorded on our system. Process a change to correct it if necessary. • Since the Pay-Direct drug system uses the date of birth to identify the patient, special handling may be required for multiple births, e.g. twins.
Incorrect relationship code is entered	Relationship codes are different for the plan member, spouse, dependent child, overage student and disabled dependent child. Plan members should ask the pharmacist to check that the code entered is correct.
Benefits are being coordinated, and your plan is second payor	Drug claims can be coordinated electronically at the pharmacy ONLY if the member and spouse both have Pay-Direct Drug plans through one of Canada's recognized Pay-Direct drug card providers. If not, the spouse must submit a claim to their plan first, and the member can then submit a paper claim to your plan for the unpaid balance.
The prescribed drug is not covered	Not all prescription drugs are covered under your benefits plan, depending on your plan design. The pharmacist can contact the doctor to see if a therapeutically equivalent drug (that is covered) can be prescribed.

If the plan member receives less than the amount they expected
A member may receive a benefit amount that is less than is specified under your plan if:

- 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 covered under your plan that cannot be purchased using the drug card. See your Benefit Booklet for a list of these items. The member will need to pay the pharmacy for these expenses and submit Extended Health Care Claim.

Note:

A predetermination is not a guarantee. In some situations, the amount of benefits paid may be different than the amount that was approved when the dentist submits the estimate (for example, if the claimant has other work done in the meantime that brings them over the annual coverage maximum under your plan, or if the work done differs from that outlined in the dentist's estimate).

Dependent records must be up to date
Claims will be declined if the dependent information has not been set up on our system. You are responsible to determine that overage dependent children continue to meet your plan's eligibility requirements (e.g. must be a full-time student or disabled and financially dependent on the member), and advise us when their coverage terminates.

When a plan member leaves your company
When a plan member leaves your company, have them return their drug card(s) to you immediately. Follow the normal process for advising us of the termination. Note: Drug cards will no longer be accepted by pharmacies once the termination date is entered on our system.

Where to call
If there is a problem with a plan member's drug card at the pharmacy, encourage the plan member to have the pharmacist call the Pharmacy Help Desk at Emergis, our drug card provider, for assistance.

If a plan member contacts you with a problem, please have them contact our Customer Care Centre. They will need to provide the following information:

- Their name, member ID number and group contract number,
- Details of the problem and the date of the transaction, and
- Name, address and phone number of the pharmacy (if applicable).

Dental Care

Dental Care coverage pays for eligible expenses that a covered person incurs for dental procedures performed by a licensed dentist, denturist, dental hygienist or anaesthetist. Benefits include preventive and restorative dental treatment in accordance with specific plan details, such as deductibles, co-insurance levels, fee guides and maximums, as outlined in your Benefit Booklet.

For each dental procedure, only reasonable expenses will be covered, up to the usual charge for the most economical alternate procedure, service or treatment consistent with accepted dental practice. In no case will the eligible expense be greater than the fee stated in the appropriate dental association fee schedule.

To submit a claim for Dental Care benefits:

Step 1 The dentist may submit the claim directly to us electronically. The member should obtain a copy of the claim submitted.

Step 2 If the dentist has not electronically submitted the form to us, the plan member and dentist need to complete their respective parts of the Dental Claim Form.

Step 3 The member should submit the claim within the time limit specified in your group contract.

If a plan member is claiming expenses for a spouse or child, see the Coordinating benefits with other plans section.

Getting an estimate
For treatments over a certain amount (specified in your contract), claimants should ask their dentist to send us a fee estimate (called a predetermination) so we can let them and their dentist know, in advance, how much (if any) of the expense will be covered by your benefit plan.

Notes:

- If a plan member is covered by Sun Life Financial for both Long-Term Disability and Life benefits, we will assess the waiver of premium claim for the Life benefit at the same time as the Long-Term Disability claim.
- Notice of claim is not required for the Long Term Disability benefit if the plan member is receiving group Short-Term Disability benefits from Sun Life Financial.
- Be sure to advise us if a plan member is receiving disability benefits under a government plan, as the plan member might be eligible for waiver of premiums

Orthodontic claims:
We will reimburse members as expenses are incurred and will pay up to approximately one-third of the full eligible treatment cost for the initial payment.

Health Spending Account

If your plan includes a Health Spending Account, please refer to the Health Spending Account Administration Guide.

Disability

Short-Term Disability and Long-Term Disability benefits provide plan members with partial replacement of lost income during periods of total disability, after the plan member completes the elimination (qualifying) period specified in your contract, and if the plan member qualifies based on the terms of the group contract.

Short-Term Disability and Long-Term Disability 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.

Each part can be submitted separately once completed, but the plan member statement and the attending physician statement should be sent directly to our group disability claims office. Claim forms must be received within the time limits indicated in your Benefit Booklet.

When a plan member returns to work, advise us immediately. If you or the plan member receive a benefit payment that includes benefits for any period during which the plan member was able to work (and therefore not eligible for benefits), the member should return the payment to us for final adjustment.

To submit a claim for Long-Term Disability 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 six to eight weeks prior to the commencement of the Long-Term Disability payments.

Life

The following is provided for information purposes only and is not intended to provide legal advice. Plan administrators should be careful not to provide opinions regarding the settlement of life insurance claims. Instead, all questions about a specific claim should be directed to our Group Life Claims Department.

Partial (advance) payment immediately upon death
Where the beneficiary is a family member (e.g. a spouse) and has an immediate need for funds, a partial claim payment (of up to $10,000) 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 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 member's death.

Note:

Depending on the circumstances surrounding the member's death, we may require more information after reviewing the claim.

We require the following information to issue partial advance payments:

- Group contract number,
- Member ID,
- Name of deceased,
- Date of birth of deceased,
- Date of death of deceased,
- Cause of death,
- Amount of insurance in force at date of death,
- Name of beneficiary,
- Relationship of beneficiary to the deceased member,
- Date last worked and reason,
- Notification of Death form,
- Member's Enrolment form, and
- Change of beneficiary form(s), if any.

We require the following information to issue a death claim payment:

- Notification of Death form (see below),
- 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.
- Election of method of settlement and statement of claim form (see below), and
- The original Enrolment form and any subsequent Beneficiary Nomination forms.
- For an Optional Life insurance claim, in addition to the above, we require:
- The original approval notice issued by Sun Life Financial issued confirming approval of the member's application for Optional Life insurance, and
- A completed Physician's Statement if death occurs within two years of coverage being approved or if the benefit is more than $250,000 and coverage has been in effect for less than five years. This is in addition to an official death certificate.

Notification of Death form

Following the death of a member or dependent, you will need to complete the appropriate section(s) of the Notification of Death form. Be sure to indicate the correct plan member ID number, group contract number, billing group number and class. You must sign and date this form to verify coverage. We should also be provided with all beneficiary forms.

Election of Method of Settlement and Statement of Claim form

If there is more than one beneficiary, an Election of Method of Settlement and Statement of Claim form should be completed for each beneficiary.

Note:

- A signed and dated Claimant Statement is considered a legal document. This statement provides authorization to allow Sun Life Financial to obtain necessary medical information, police report, coroner's report, etc.
- Plan administrators should avoid giving an opinion on how the will is to be applied. Once we review a copy of the will, we will provide that information.

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

For life insurance amounts we require	
Less than $50,000	No additional documentation
More than $50,000, but less than $100,000	Notarized copy of the will Note: If the deceased plan member was a Québec resident who designated their estate as beneficiary and the proceeds exceed $50,000, we require a notarized copy of the notarial will.
Exceeding $100,000 and the deceased plan member was a resident of	
Ontario	Notarized copy of the Certificate of Appointment of Estate Trustee with a will
Québec	Notarized copy of the notarial will
Any other province	Notarized copy of the probated will

If there isn't a will

For life insurance amounts 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
In order to apply the terms of a will to the group Life benefit, the will must be dated later than the Enrolment form (if the Enrolment form designates a different beneficiary than is shown in the 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.

Note:

- Each province has its own legislation concerning payments to a legal guardian on behalf of a minor.
- If a beneficiary is interested in exploring other payment options, we'll direct them to their nearest Sun Life Financial advisor who can explain the options available to them.

If the beneficiary is a minor

- If a trustee has been appointed, the trustee should complete the claim form and include documentation showing their appointment. We will pay the proceeds to the trustee on behalf of the minor.
- In Québec, the surviving parent is the Sole Tutor for the minor and should complete the claim on their behalf. If there is no surviving parent and an administrator has not been designated, a court-appointed Tutor must make the claim.
- If there is no trustee in place and a Legal Guardian for Property has been appointed for the minor, the legal guardian should complete the claim form and provide documentation showing their appointment.
- 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

While we offer beneficiaries a number of payment options, payment by cheque is by far the most common. We will issue the cheque in the beneficiary's name and send it to you. You are then responsible for arranging the delivery of the cheque to the beneficiary.

Criminal offence

If the beneficiary is charged with a criminal offence related to the death claim, we cannot settle the claim until the criminal charge has been cleared. Under Canadian law, no one can benefit from a criminal offence.

Beneficiary pre-deceases member

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

Simultaneous death

If the beneficiary and the 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 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 member's estate, or, if there was more than one beneficiary, the proceeds may be shared among the remaining surviving beneficiaries, or the deceased beneficiary's share may be paid to the member's estate. (See Naming a beneficiary section.)

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

Note:

- If a member is within 5 years of a scheduled termination they are not 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, you should contact your Sun Life Financial group representative to discuss the possible financial implications to your contract.
- Copies of the employee's enrolment form(s) should be submitted on all Waiver of Life Premium claims regardless as to whether Long-Term Disability is with Sun Life Financial or not.

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 per cent of the Basic Life insurance amount, to a maximum of $100,000. If the member is within five years of a scheduled reduction of Basic Life insurance, the maximum Living Benefit payable will be 50 per cent 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 beneficiary(s) on the member's death.

Other claims

Waiver of Life Premium

The waiver of 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, subject to the terms of the contract that were in effect on the date the member became disabled, including reductions and terminations. Where Sun Life Financial provides the Life benefit but not the Long-Term Disability benefit, we require the following information in order to assess the Waiver of Life Premium claim:

- Employer's statement
- Waiver of premium claim – Claimant's statement
- Waiver of premium claim – Attending physician's statement of disability

Accidental Death & Dismemberment (AD&D)

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

Critical Illness Insurance

To make a claim for Critical Illness Insurance, the member should contact us, and we will send them the required forms. Our claim forms are clear and thorough, and we will contact the member directly throughout the claim process to keep them informed of the status of their claim. We will correspond directly with the physician and /or the hospital, if necessary, to obtain any additional medical information we need.

Administration and claim forms

To help you with the administration of your plan, our standard forms have been posted to the Plan Sponsor site under the Guides & Information section.

As well forms can be obtained without an Access ID or password

Step 1 Go to our website at **www.smallbusiness.sunlife.ca**

Step 2 Select "Forms"

Step 3 A list of forms in alphabetical order will be displayed and are available to download and print

Contact information

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

Visit our website at **www.sunlife.ca** to find useful information and contact information.

SunAdvantage Client Services can be reached at:

Hours of operation:
8:30 AM - 4:30 PM EST Eastern, Ottawa, and Central Regions
9:30 AM - 6:30 PM EST Western Region

Phone number: 1-877-786-7227
Fax number: 1-877-823-6605 or (514) 399-1107

Mailing address:
Sun Life Assurance Company of Canada
SunAdvantage Department
PO Box 11010 Stn CV
Montreal QC H3C 4T9

Courier:
Sun Life Assurance Company of Canada
SunAdvantage Department
1155 Metcalfe St
Montreal QC H3B 2V9

Web site address: **www.smallbusiness.sunlife.ca**

Sun Life Financial

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