Plan Sponsor Services

SunAdvantage Group Benefits Administration guide

Published November 2020

Use this guide for client-administered group plans if you use our Plan Sponsor Services Group Benefits Administration website.

Our guides are stored and regularly updated on our Plan Sponsor Services **Guides for Group Benefits Administrators** page.

Life's brighter under the sun

Sun Life

Contents

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're key elements of our web security, created to protect you and your plan members' information.

Welcome to Sun Life's Plan Sponsor Services (PSS) – Group Benefits Administration (GBA). It's our customer-driven, web-based tool. It lets you handle the most simple and the most complex aspects of your group benefits program. GBA makes record keeping quick and easy. And, puts information at your fingertips, when you need it most. We also provide Health Spending Account (HSA) and Personal Spending Account (PSA) administration guides, if related to your plan.

With our Plan Sponsor Services website, you can:

- enroll plan members, update their records
- terminate or reinstate plan members' coverage
- view, print or save plan members' coverage summaries and drug cards (if applicable)
- view details of your benefits plan coverage and set-up
- download Client contracts, booklets and plan documents
- 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'll need:

- Windows 10 or higher
- 128 bit encryption
- Microsoft Adobe Acrobat Reader 8.0 or higher
- the latest browser version with all the applicable security patches installed (We recommend this for improved security, performance and support.)
- access to your browser provider's website (to verify that you have the latest browser version available):
    - Microsoft Internet Explorer
    - Google Chrome
    - Mozilla Firefox
    - Apple Safari
- a plan sponsor Access ID and password
- this Administration Guide, your group benefits contract, and
- your benefits booklet – available within the Contract & documents page

Your Access ID and Password

Security is critical when you're using the internet to manage your benefits plan. Here are some of the ways we protect and keep your data private:

- Our password-protected website
- Strong encryption
- Firewalls, and
- A high level of physical security at the server site

Your Client 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 sunlife.ca/sponsor. Then, enter this information in the correct fields and click **Submit**.

The first time you use our website, we'll ask you to:

- change your password immediately – for security reasons
- enter your date of birth
- choose a verification question from the list provided and enter an answer that only you know.

Benefit Summary

This document provides a summary of the most commonly viewed benefit information. And, it's available to you on the Contract & documents page.

By registering online at **mysunlife.ca**, members can view their full benefit booklet. It includes the Benefit Summary as well as access their ID, Drug and Travel cards (if applicable).

If you forget or lose your password in the future, you can reset it online by selecting **Forgot your Access ID**. Then, enter the date of birth you first provided, and answer the identity verification question correctly. This information will allow the system to validate you as a registered user.

If you haven't already done so, you should also submit a current and valid e-mail address. When done, you'll receive an e-mail from Sun Life. This will confirm that your password was re-set. Please follow the instructions in that email, to complete the validation process.

As a GBA plan administrator, it's up to you to maintain your plan member records directly on our administration system. We use this information to prepare your monthly premium bill.

We designed this guide to help you manage your plan member records on our system. It describes the procedures you should follow in the day-to-day administration of your plan. You can use it, along with your group benefits contract and benefit booklet, to do so.

Another key part of your role is to update all required plan member information on a timely basis. That will enable us to pay claims and prepare your monthly premium bill on time.

Be sure to keep all plan member enrolment forms and changes, including beneficiary designations, at your location.

We designed this guide to reflect your benefit plan. But, you may find references to benefits or provisions that don't apply to your plan. Please disregard those references.

Note: This guide does not override the terms and provisions of your group benefits contract. You're responsible for administering your plan according to the terms of your contract.

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

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.

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** (FAQs) for the information you need.

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

- Store all member information in a safe place.

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

  Ensure you provide a Coverage Summary form to the member whenever a change of information occurs.

Getting started

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

- Select an application
- Read messages about relevant topics
- Select links to useful information

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

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

Navigation bar	You can get access to the full range of options for administering your benefits from the navigation bar. It's located at the top of the page. Select **Members, Billing & Reports or Guides & Information** to display the dropdown menus.
Group Benefits	To return to the Group Benefits Administration Welcome page, you can select **Group Benefits** at any time.
Help	You can get help on how to switch to your preferred language, change your profile and other topics, on our website.
Contact us	Here you'll find the number to call when you want answers to your questions.
Profile	You'll need to select this option if you want to change your password, your verification information, or your e-mail address. (You must enter your email address before you can re-set your password.)
Sign Out	You must click on this button to sign out and protect your data.
Quick Links	You can use these to links get easy access to popular features.
View a member	Use this feature to search for plan members by name, ID or by using a "wildcard" (a handy feature when you have limited information with which to search). Save and/or print copies of your plan member's coverage summary and drug card (if applicable).
Members	Get quick access to the most commonly used plan member features, by clicking this button.
Guides & Information	You can get quick access to reference resources, including your contract updates, benefit booklet and other documents related to your plan.

Member information

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

- view a member
- add a member
- update a member
- reinstate a member
- terminate a member
- make special requests
- update many salaries

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

About effective dates

For most plan member changes you process on our GBA website, you'll need to enter an effective date of change (the date you want the change to apply).

Tips

Adding a new plan member
Member information
- Enter the plan member's hire date and our system will apply the waiting period, if applicable, to calculate the effective date.

Benefit information
- Our 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 plan member returns to work.
- If there are no waiting periods, the effective date is the date the plan member returns to work.
- If there are waiting periods, the effective date is the first date after the waiting period ends

Terminating a plan member
Member information
- The effective date is the date the plan member's coverage ends

Types of plans and effective dates

What 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.

To ensure you enroll 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 includes a waiting period, plan 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 for coverage to become effective.

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 member is considered a late applicant. The member and the 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 Quebec, the 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.

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

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., a 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 any coverage requiring proof of good health (see Enrolling in the plan section)

Benefits become effective on the later of the date the plan 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 plan members cannot pick and choose benefits.

*The most common type of comparable coverage is a spouse's plan. But, 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 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 is not 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 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 member will have to reapply for any optional coverage.
- The 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.

If your plan has optional benefits

Your plan may include optional benefits such as Optional Life, Optional Accidental Death & Dismemberment and Optional Critical Illness. Some optional benefits require proof of good health and a **Health Statement** form must be completed. Coverage becomes effective on the later of the date the member or dependent is eligible or the date the **Health Statement** is approved. (See your group contract for details.)

If your contract has Critical Illness

If the plan member is applying for Optional Critical Illness or is a late applicant for Critical Illness, provide the member with the application for Critical Illness Insurance, which includes enrolment information as well as their health statement. If applicable, the spouse section of the form must also be completed. Advise the member to send the application directly to us. Mailing instructions are provided on the form.

If the plan member is applying for both Optional Life and Optional Critical Illness benefits, the member will receive separate notification of our decision.

Enrolling in the plan

Notes:

When plan member data is added to our administration system, it is transferred 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 enroll plan members in the benefits plan as soon as they are hired. This applies even though they'll need to go through a waiting period before they qualify for coverage.

The Enrolment Guide

Step 1 Complete the first section of the Enrolment form for each plan member. The form is included at the back of the Enrolment Guide available within the Contract & documents page as well as on the Guides & forms page.

Step 2 Provide the plan member the Enrolment Guide and form, have the plan member complete the remaining sections of the form and return it to you.

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

Step 4 Enter the plan member on the GBA system. A coverage summary, including a link to the drug card (if applicable) will automatically be generated. You can download and/or print both documents and give these to the plan member.

Step 5 File in your member records file.

Please note the Enrolment Guide provides the plan member:

- a fillable drug and travel card (if applicable)
- important information on how to access their benefit coverage online
- a copy of the Benefit Summary of their plan benefit coverage.

Plan members can access their benefit booklet with full benefit details on our website at **mysunlife.ca**. If the member needs more cards, they can sign into our website to print extra copies.

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 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 form** 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 or spouse is applying for the first time or increasing Optional Critical Illness or Optional Life benefits.
- A member's Life or Long-Term Disability amount exceeds the non-evidence maximum (NEM). (Your contract will indicate if your plan has an NEM.)
  - First-time coverage exceeding the NEM, and thereafter if there is:
  - An increase in the Life benefit of at least 25 per cent of existing coverage or $25,000, whichever is greater.
  - An increase in the Long-Term Disability benefit of at least of 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** 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 will 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.

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: 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.

Naming a beneficiary

Notes:

- When a member updates their beneficiary, you should ensure that they are not attempting to change a previous nomination of an irrevocable beneficiary. (Please see 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 stating the beneficiary's full name and relationship to the member.

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

- complete, date and sign a new form (member must initial any changes and correction fluid can't be used)
- use a digital tool provided by the Plan Sponsor (designed in-house or through a TPA)

The Sun Life Digital Beneficiary tool

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 the PPHP 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.

Notes:

- You can view nominations but are unable to make updates in the digital beneficiary tool.

Using the Sun Life Digital Beneficiary tool

- plan members should be encouraged to use the Sun Life digital tool but paper forms will still be accepted
- 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
  - 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 Quebec
  - 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), and Scans

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 having an e-signature
  - 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).

You should 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 Quebec
  - in Quebec, 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 Quebec employees that:
  - designation of their legal spouse is irrevocable unless the designation is clearly marked revocable
  - they will not be able to change their nomination or reduce their life insurance coverage without the written consent 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.

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 Quebec, 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 — 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 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 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 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 Quebec table below);
- Proof of death of the irrevocable beneficiary.

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 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

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 on or after 20/10/76 and before 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 on or after 20/10/76 and before 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

Note:

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

More about beneficiary designations

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

Scenario	Additional information
Designating one beneficiary	To designate one beneficiary, the member must complete the name and relationship of the beneficiary.
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 percent. An equal distribution will be assumed if there are no percentages indicated.
If your plan has Optional Life benefits	The member may designate separate beneficiaries for Basic Employee Life, and Optional Employee Life. The member needs to complete each of the applicable sections of the Enrolment form or Beneficiary Nomination form. If the member wishes to designate the same beneficiary for basic and optional benefits the employee can complete the 'Same beneficiary for all benefits' form. The member is the beneficiary by default for any Optional Spousal benefit.
Appointing a contingent beneficiary	To appoint a contingent beneficiary, the member should 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 Quebec	In Quebec, a 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 member designating the estate 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 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 Quebec). These costs are not incurred if proceeds are payable to a named beneficiary. Note: Plan members cannot name a bank or financial institution as their beneficiary for purposes of providing collateral for a loan.
When no beneficiary has been designated	Proceeds will be paid to the member's estate.

Maintaining plan member records

Notes:

When plan member data is updated in our administration system, it is transferred 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.

- Once updates to the plan member record have been made, an updated coverage summary and link to drug card (if applicable) will automatically be generated which can be downloaded and/or 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.

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 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 in the benefit plan with single coverage requests a change 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 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.)

[1] A Health Statement form is required for any existing dependent not already covered.
[2] If a resident of Quebec, the 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.

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

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

Notes:

Once updates to the plan member record have been made, an updated coverage summary and link to drug card (if applicable) will automatically be generated which can be saved and/or printed and distributed to the plan member.

Updating student information

Coverage for a dependent child ends at the lower age limit specified in your contract. 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, the learning institute that the dependent goes to must consider them a full-time student. We'll also consider co-op and apprenticeship programs. But, the overage student must not be receiving Employment Insurance (EI) while they are in school.

An overage student does not have to be living with the plan member to qualify as a dependent. And, 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. This can be done through the Update a member page.

GBA (if you use Sun Life's online Plan Sponsor services site for your administration)

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 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
- On the date the student graduates

We'll allow coverage to continue for an overage student through the summer term, if the student completed their year of studies. But, they must be returning to their studies in September.

Your members should keep you up to date with any changes to their dependents' status. You should also confirm with your members at least once per year whether their dependents are still enrolled full-time or will be enrolled full-time in the upcoming year.

For claims, the member must declare that the dependent is an overage student each time a claim is submitted.

If your policy includes dependent life, we may ask for proof of enrolment if a death claim is received and will use this to validate whether a dependent is eligible for a claim payment. It is crucial that the member 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
https://www.cicic.ca/868/search_the_directory_of_educational_institutions_in_canada.canada	https://www.cicic.ca/976/get_information_on_applying_to_study_abroad.canada

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 member's eligible dependents must complete a Health Statement to verify proof of good health. There may be a maximum limit 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 provide proof of good health. There may be a maximum limit for Dental.

Terminating coverage

You need to update the GBA 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 can 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

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

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.

Statutory leave

You need to continue all coverage while a member is on statutory leave. You need to arrange 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 statutory leave period.
- You must let us know when a plan member's optional benefits is ending. We'll treat the cancellation of the optional benefit as a refusal. But, if your plan member re-elects the benefit, a **Health Statement** will be required.
- 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 statutory leave period:

- Benefits previously in force should be reinstated immediately when they 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 date's 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 based on the terms of your contract, if provided under your plan. Let the survivors 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 they may choose 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).
- The plan member must nominate a beneficiary, if choosing optional benefits for the first time.

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.

Administrative reports

- **Coverage Summaries** provide a member's:
    - current address,
    - benefit details,
    - dependent details, and
    - 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 sent 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 **Guides & 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** page. If the overage dependent is not a student, terminate their record on the **Update a member** page.

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 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 conditions that 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 60 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 60-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

Our website is designed to make benefits administration as easy as possible. However there are some transactions you need to submit to Sun Life for processing, since they need special attention. Send us the details for these transactions through the Special Requests feature on the Members menu, which includes:

- Waive a waiting period/Change member and benefit effective dates
- Change member ID, location, plan, classification or hire date
- Change benefit termination dates
- Request for other changes

Step 1 For all admin exception requests, provide all relevant information about the request within in the Member menu, Special Request feature

Step 2 We will advise you of our decision. If approved, we will outline the terms of the approval. Or we'll review the requests and respond to you within 48 hours to confirm the status of the request.

Administrative exceptions that require special handling

- **Waiver of waiting period** requests should be completed through the Special Request feature. We will consider the request to waive the waiting period and notify you of our decision.
- **Coverage for temporary work stoppages** such as layoffs, strikes, statutory 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 statutory leaves, the longer of the province's legislated statutory 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?

You must include premiums for some benefits paid by plan sponsors, to their employees, as income. This depends on the province where they live or work. You must show the value of these taxable benefits when you report members' income during the year, and when you issue their tax slips.

Below is a quick overview of which employer-paid premiums are considered taxable. We do not intend for this information to be tax advice. **We recommend that you consult a tax advisor about calculating taxable group benefits.**

Employer-paid premiums/contributions and sales tax	**Income Tax Act**	**Income Tax Act (Québec)**
Employer-paid premiums/ contributions and sales tax that are a taxable benefits for employees	• Group life insurance • Group Sickness or Accident insurance plans (e.g., Critical Illness, Accidental Death & Dismemberment) • Personal Spending Account	• 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)
Employer-paid premiums/ contributions and sales tax that are not a taxable benefit for employees	• Disability benefits (short and long-term) – when disability claim payments are taxable income • Private health services plan, such as Medical, Dental and Health Spending Account	• Disability benefits (short and long-term) – when disability claim 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**

Canada Revenue Agency (CRA) establishes what group benefits must be included as taxable member income in the province in which the member works or resides. You can find a comprehensive list of these benefits at cra-arc.gc.ca/menu-e.html.

More information for members who live or work in Québec, including taxable benefit information and requirements, can be found at revenuquebec.ca/en/

The information regarding members who live or work in the province of Québec is to be used by Sun Life customers who've entered into an insurance contract with us. Plan sponsors with an administrative services only (ASO) arrangement with Sun Life, and have members in Québec, should refer to the Revenu Québec website.

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 website. 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. You must pay them within the grace period specified in your contract. If you don't pay your premiums within this grace period, your claim payments could be suspended until we receive payment.

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 Guides & 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.

Guides & Forms

Here you'll find the most commonly used guides and forms you need to manage your plan. Included on the page is a link to the public SunAdvantage forms page. This includes a comprehensive list of all administration forms. If you cannot find what you're looking for, please contact your Client Service Administrator.

Contract & documents

Here you'll find a copy of your Contract, Focus Update, Benefit booklet and other plan documents applicable to your group benefit plan.

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

my Sun Life Mobile app: Plan members who download the **my Sun Life Mobile app** can submit and track benefits claims on the go.

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 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). Claims are submitted immediately and processed fast.

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

If members lose their card or need extra copies for family members, they can print drug cards from our website at mysunlife.ca. Also available on the **my Sun Life Mobile app**.

Paper – Mail

Plan members can mail complete Extended Health Care, Dental Care, Health Spending and Personal Spending Account claim forms, along with their original receipts, to the claim office listed on the back of the claim form.

Members can download a personalized claim form from **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. It's also important that you ensure all claim forms are fully completed, and that we receive them 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. All insurers use insurance industry guidelines to determine which plan their claim should be sent to first. Here are the guidelines:

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 birthdate (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.

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.

Member can access their Drug cards online within **mysunlife.ca** and the **my Sun Life mobile app**.

You can access cards within the View a member page.

If both spouses' benefit plans are administered by Sun Life: The member can direct us to pay from both plans as part of the same claim. The member completes the appropriate section of the Extended Health Care and/or Dental claim form, showing the both benefit plan's contract and member ID number. The spouse must sign the claim form to allow 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.

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 available within the Contract & documents page.) 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.

Hospitals normally submit claims for hospital expenses directly to us, and we pay the hospital directly. And, we send the member a claim statement that shows what was claimed and what we paid.

Note: Members should check their claim statement to ensure they actually received the services that were 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 AZGA Service Canada Inc. (Allianz Global Assistance), our travel assistance service provider, immediately and
- follow the instructions in their Travel Benefit pamphlet (available at **mysunlife.ca**) To claim non-emergency, out-of-province medical expenses, members must complete an Extended Health Care Claim through methods outlined above.

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.

Drug cards are used to purchase prescription drugs only. They are accepted at most drugstores across Canada. Plan members 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)

A drug card is available for the member within the

- **Member site.** Members can sign into mysunlife.ca to print extra copies for themselves.
- **The my Sun Life Mobile app**: Plan members who download the **my Sun Life Mobile app** can use their smartphone as a drug card.

As well, printing and saving a drug card for a plan member is a feature available to you within the View a member page.

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 the birth is entered	• When submitting a prescription, the pharmacist will ask for 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 is declined. • Plan members should ask the pharmacist to check if they entered the correct date of birth. 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, relationship code 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 second payor 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. These limits ensure you don't 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 your plan members can't purchase with their drug card. See your Benefit booklet available within the Contract & documents page for a list of these items. The member will need to pay the pharmacy for these expenses and submit an 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

We may decline claims if the dependent information has not been set up on our system. It's your role to verify that overage dependents continue to meet your plan's eligibility requirements. Plus, let us know when their coverage ends.

Overage dependents must be a full-time student or disabled, and financially dependent on your plan member.

Lost or stolen cards

If a plan member loses their drug card or it is stolen, they can obtain a new card from

- my Sun Life Member Services website or use the cards available on the **my Sun Life mobile app**. Paper and mobile app drug cards are accepted by all participating pharmacies.
- You can notify your Group Client Services administration contact immediately and request a replacement card.

When a plan member leaves your company

Please follow the normal process for terminating the member within the Terminate a member page. Drug cards will not be accepted by pharmacies once the termination date is entered on the system. You should have the plan member destroy their drug card(s) immediately.

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 Telus, 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

With Dental care benefits, your plan members are covered for procedures done by:

- a licensed dentist
- denturist
- dental hygienist, or
- anesthetist

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 available within Contract & documents page.

Notes:

- If a plan member is covered by Sun Life 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.
- 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

We'll cover reasonable expenses for each dental procedure, up to the usual charge for:

- the most economical alternate procedure, and
- service or treatment consistent with accepted dental practice.

Plan members' eligible expenses must not 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). We can let them and their dentist know, in advance, how much (if any) of the expense will be covered by your benefit plan.

Orthodontic claims

We'll repay members as expenses are incurred. We'll pay up to about 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. This is available within the PSS – Guides for Group Benefits Administrators page.

Personal Spending Account

If your plan includes a Personal Spending Account, please refer to the Personal Spending Account Administration Guide. This is available within the PSS – Guides for Group Benefits Administrators page.

Disability

Short-Term Disability and Long-Term Disability benefits provide your plan members with a portion of their lost income, during periods of total disability. Members must complete the elimination (qualifying) period specified in your contract. They must qualify for these benefits based on the terms of your group contract.

Note:

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

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, available within the Contract & documents page.

When a plan member returns to work, let us know immediately. If you or the plan member get a benefit payment that includes benefits for any period during which the plan member was able to work (and doesn't qualify for benefits), the member should return he payment to us for final adjustment.

To submit a claim for Long-Term Disability benefits, or to have premiums waived under the Life and Accidental Death & Dismemberment benefits, be sure you fill out the relevant claim forms. Then, send them to us six to eight weeks before the start 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 **group.life.claims@sunlife.com**.

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 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 member's death.

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

- Notification of Death form,
  - 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,
  - Date last worked and reason,
  - Member's Enrolment form, and
  - All beneficiary designations .
  - Directions from the Plan Sponsor on where to send payment, directly to the beneficiary or elsewhere.

Note:

- A signed and dated Claimant Statement is considered a legal document. This statement provides authorization to allow Sun Life 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. 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.

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**, any subsequent **Beneficiary Nomination forms** and a copy of **any will that contains a beneficiary designation**.
- For an Optional Life insurance claim, in addition to the above, we require:
  - The original approval notice issued by Sun Life 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 medically approved by Sun Life's underwriting 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.

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

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 designations**.

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.

Estate claims

When the benefit is payable to the 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

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.

- 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.

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.

If the beneficiary is a minor

Non-Quebec

- If a trustee has been appointed, the trustee should complete the Claimant Statement. We will 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 should complete the claim form and provide documentation showing their appointment

Quebec

- In Québec, the surviving parent is the Sole Tutor for the minor and should complete the claim 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

How proceeds are paid

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.)

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

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 group benefits 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 or not.

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.

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. This is subject to the terms of the contract that were in effect on the date the member became disabled. It includes reductions and terminations.

Where Sun Life provides the Life benefit but not the Long-Term Disability benefit, we require the following information 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 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 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.

Accidental Death

To make a claim for Accidental Death you must provide documentation to support the death as being the direct result of an accident. These documents can be a police or coroner's report and, if available, newspaper clippings that outline the details of the accident (obituary notices are not sufficient).

Critical Illness Insurance

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

The Call Center will take basic details including the nature of the illness claimed. The Physician forms (APS) are specific to the condition claimed. The claims area will e-mail a claim package to the member. The package contains the required forms and information to assist the claimant. Instructions include how to complete and return the forms. We ask for the medical information we need to speed up the process.

If coverage is less than $100,000, we can pay the benefit by direct deposit. We send an authorization with the claim package.

Administration and claim forms

To help you with the administration of your plan, our standard forms are posted to the Plan Sponsor site. Find this under the Guides & Information section within the Guide & Forms page.

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

Step 1 Go to our website at sunlife.ca/smallbusiness

Step 2 Select "Forms"

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

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
10	Naming a Beneficiary	Updating beneficiary information
		The Sun Life digital beneficiary tool
11	Using the Sun Life Digital Beneficiary tool	New section added
11-12	Electronic beneficiary (e-beneficiary, electronic signatures), and Scans	New section added
34	Estate claims	Chart outlining when the benefit is payable to the member's estate
Appendix B	CLHIA	Process on Electronic Declarations

Appendix B — CLHIA Process on Electronic Declarations Contact information

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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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 **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 ET Eastern, Ottawa, and Central Regions
10:30 AM – 7:30 PM ET 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
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1155 Metcalfe St
Montreal QC H3B 2V9

Web site address: sunlife.ca/smallbusiness

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