SunAdvantage Administration Guide

for Sun Life administered group plans

Published November 2020

Use this guide if Sun Life administers your plan members' Benefits plan and prepares your billing statements.

Find our guides on our SunAdvantage Forms page.

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Sun Life

Contents

Introduction

As a plan administrator, you have an important role to play. We've designed this guide to help you with your role. This guide describes the procedures to follow for the day-to-day administration of your plan. These practices help to ensure that we provide coverage and pay benefits, according to your plan's terms.

We also created two companion guides:

- Health Spending Account Administration Guide
- Personal Spending Account Administration Guide

Please refer to the guide related to your plan.

A key part of your role is to provide us with all the plan member information. We use this information to pay claims and calculate benefit premiums in a timely manner.

We store all plan member data, including beneficiary designations, on our administration and claims systems. You must let us know about any changes to your plan member records, as soon as possible. That includes changes in earnings, coverage and dependent status. You need to keep a copy of all the information you send to us.

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

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

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

- the plan member's full name and
- Member ID.

Protecting plan members' privacy

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

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

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

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

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 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.

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

If your contract contains Health, Accident or Disability benefits, and your business is in Québec, your contract must follow 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. 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 coverage that requires proof of good health (see Enrolling in the plan section)

Benefits are effective on the later of:

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

When a plan member refuses coverage

As a result of comparable coverage:

- Plan members refuse Extended Health Care and/or Dental Care benefits because they have comparable coverage under another group plan*. Members may refuse coverage for themselves and their dependents, or their dependents only.

Other than for comparable coverage:

- Mandatory plan: Members cannot refuse coverage if the plan is mandatory.
- Non-mandatory plan: A member may refuse all coverage or all dependent coverage, but members can't 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: Plan members must provide you with all refusals in writing, for future reference. Make sure the 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.

Enrolling in the plan

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

The Enrolment Guide

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

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

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

Step 4 Make a copy of the completed **Enrolment** form for your file. Then, send the original copy to **SunAdvantage Client Services** (see **Contact information** on page 33).

Step 5 You'll receive a **Member Change** Form. Use this to confirm that we have recorded the plan member information on our systems. Review this form to ensure the information is accurate. You will also receive a wallet ID card to give to the member.

Please note the **Enrolment Guide** provides the plan member with:

- 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 coverage

Plan members can access their benefit booklet, drug, travel and Member ID cards at **mysunlife.ca**. If a member needs more cards, the member can sign into our website to print extra copies.

Certain sections of the Enrolment Guide will not apply if:

- a member or their dependents are currently covered under another group plan for Extended Health Care and/or Dental
- a member has refused benefits under this plan

Note: When you upload plan member data to our administration system, it is added to our claims system. Then, we transfer it to our pay-direct drug system the next night. Any claims we process during this period will not reflect the new data.

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.

Advise your plan member to complete the non-smoking declaration if:

- your plan has Optional Life with smoker/non-smoker rates
- Your plan member is a non-smoker, and
- your plan member chooses Employee Optional Life

The plan member's spouse must also complete the non-smoking declaration, if the member chooses the Spouse Optional Life benefit.

Note: Incorrect information about the non-smoking status of the member or spouse may invalidate a claim for Optional Life.

When proof of good health (Health Statement) is required

A **Health Statement** form is required when a plan member:

- is a late applicant (see **Determining effective dates**)
- originally refused benefits in a non-mandatory plan and is now applying for coverage
- is applying for Optional Life benefits or other voluntary benefits, or
- the Life or –Long-Term Disability amount exceeds the non-evidence maximum (NEM). (Your contract will indicate if your plan has an NEM and the amount of the NEM.)

If your plan has NEM coverage, your member must submit proof of good health when they first apply for coverage that exceeds the NEM amount. Then, a plan member must submit proof of good health if they:

- increase Life coverage by at least 25% of existing coverage or $25,000 – whichever is greater
- increase Long Term Disability coverage by at least 25% of the existing coverage or $500 per month – whichever is greater

Submitting a Health Statement form

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

Step 2 Advise the plan member to answer all questions on the form. This will ensure their coverage is not delayed. The plan member must also complete the spouse and/or dependent sections of the form if this applies.

Step 3 The information requested on the **Health Statement** is highly confidential. So, let your plan member know they must send the completed form directly to us. We've included mailing instructions 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.

If your plan has optional benefits

Your plan may include optional benefits such as Optional Life and Optional Accidental Death & Dismemberment. We usually require the member to complete a **Health Statement** for optional benefits.

Statement must be completed. Coverage becomes effective on the later of:

- the date the member or dependents are eligible or
- the date the **Health Statement** is approved. (see your group 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.

Naming a beneficiary

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)

Note: 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.)

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

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

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

Plan members can enter designations in 2 ways:

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

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

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

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

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
    NOTE: You can view nominations but are unable to make updates in the digital beneficiary tool.
  - add a space between the letters 'l' and 'r' of a beneficiary name that contains the consecutive letters 'irr'
  - ensure you include 'revocable' or 'irrevocable' for a beneficiary with a relationship of spouse, in the province of 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 beneficiary designations or reduce their life insurance coverage without the written consent of the irrevocable beneficiary.

Revocable and irrevocable beneficiaries

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

In 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.

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

Beneficiaries in Québec

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

Spouses designated after 20/10/76

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

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.

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

Maintaining plan member records

It's important that you keep plan member information up-to-date at all times. This ensures that your monthly premiums are totalled 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

Here are the steps in the member change process:

Step 1 The plan member lets you know when they need a record change (e.g., new spouse).

Step 2 You record the change on the Member Change Form. Then send the completed form to us by mail, fax or email.

Step 3 We update our systems to show the change.

Step 4 We send you an updated Member Change Form. We'll also send you a new wallet ID card for the plan member, if their information has changed.

Step 5 You review the updated Member Change Form to verify that the information was updated correctly.

Step 6 You file the Member Change Form and use it for the plan member's next change request.

Note: When we change a plan member record in our administration system, the new data is transferred to our claims system. Then, we transfer it to our pay-direct drug system the next night. If we process claims during this period, the new data will not show.

Change from single to family status

When a plan member wants to change coverage and requests a change from single to a 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** to verify proof of good health[1]	The date the **Health Statement** is approved, and we will notify you in writing of the approval. (There may be a restricted maximum for Dental)

[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.

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 for coverage as an overage student. See the "Determining eligibility" section on page 2 for the definition of an overage student.

To qualify as an overage student, their learning institute must consider them a full-time student. We'll also consider co-op and apprenticeship programs. But, the overage student must not be receiving Employment Insurance (EI) while they're in school.

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

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

- Group Benefits Enrollment (GBE) (if you use Sun Life's online Plan Sponsor Services website for your administration)
- your tape file feed to Sun Life
- by contacting our member administration team

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

Coverage for an overage dependent ends:

- on the first day of the next term – if the student doesn't return to full-time studies
- on the date the student graduates

We'll allow coverage to continue 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 on changes to their dependents' status. They must also declare that the dependent is an overage student each time they submit a claim.

At least once a year, confirm that your plan members' dependents are still enrolled in a learning program full- time. The dependent must be enrolled as a full-time student for the upcoming year.

If your policy includes dependent life, we may ask for proof of enrolment if we receive a death claim. We'll use it to verify that a dependent qualifies for a claim payment. The plan member must keep their dependent status up-to-date.

How to determine if a school or college is accredited?

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

In Canada	Outside Canada
cicic.ca/868/search_the_directory_of_educational_institutions_in_canada.canada	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 day after the other coverage (e.g., spouse's plan) end date	• Coverage start date should be the day after the other coverage end date. The plan member must request coverage within 31 days of this date. • If coverage is not requested within 31 days after the other coverage ends, the plan member is considered a late applicant. The member and the member's eligible dependents must complete a **Health Statement** to provide 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 member is considered a late applicant. The member and the member's eligible dependents must complete a **Health Statement** to provide proof of good health. There may be a maximum limit for Dental.

Terminating coverage

We end plan members' coverage when their employment ends, or if the member is no longer actively working. But there are exceptions to the actively working requirement, such as statutory leaves, layoffs and disability leaves. Check the continuation of coverage provision in your contract to learn if coverage can continue or if it must end. If coverage does end, then you must notify eligible members of their right to apply to convert their group life insurance to an individual insurance policy.

Please see the **Purchasing individual insurance when benefits end or reduce** section on page 16.) If your benefit plan has Extended Health Care or Critical Illness coverage, then when your plan member calls Sun Life, we will tell them about their other rights to transfer such coverage.

Changes due to age or retirement

We may reduce or end a plan members' coverage at a certain age, or when they retire. Dates may vary from one benefit to another. You don't have to let us know about age-related changes, or changes due to retirement. We set our system to automatically process the change on the appropriate date.

For plan members who remain on disability claim until age 65, they are deemed retired. Check your contract for the definition of Retirement Date.

Your plan member and their spouse can apply to convert their life insurance coverage to an individual policy. They can do so when we reduce or end their coverage. Be sure to refer your plan member to Sun Life. They'll need to call us to have their life insurance converted within 31 days. As noted above, there may be other individual insurance options available to them too. (See **Purchasing individual insurance when benefits end or reduce** section on page 16.)

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

We'll update our systems 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 is approved

Statutory leave

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

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

We also allow members to waive non-taxable Long Term Disability (LTD) coverage and/or optional coverage (e.g. Optional Life), during a statutory leave. But, you should encourage your plan members to keep all coverage in place.If they choose not to, then you'll need to have them sign Sun Life's waiver and release form.

Continuing coverage during a leave

- You don't need to notify us if all coverage is continuing for the province's legislated statutory leave period.
- Plan members cannot choose to continue some benefits and cancel others.
- However, plan members can choose to waive optional coverage (e.g. Optional Life or Critical Illness) or non-taxable LTD coverage or both.
- You must notify us if plan members cancel all coverage or choose to cancel optional and/or non-taxable LTD coverage only.

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

- Previous benefits coverage should be immediately reinstated when they return to work. We will not enforce the waiting period.
- Reinstatement of coverage follows the mandatory/non-mandatory plan rules outlined earlier. (See **Types of plans and effective dates** section on page 2.)

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

- If your plan member re-elects optional coverage when they return to work, they'll need to complete a Health Statement and send it to us. We'll re-instate non-taxable LTD coverage, and we'll use the plan member's coverage effective date (in place before the leave began) for the pre-existing condition provision.

About RAMQ:

Your contract must comply with Québec Drug Insurance Plan requirements if:

- your contract contains health, accident or disability benefits
- you have a place of business in Québec

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

If a plan member dies

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

Plan members must follow the instructions found in the **Submitting Claims** section.

Adding or changing Optional Life benefits

If your plan has optional benefits, members may decide to add them after they've enrolled. Or they may choose to increase the amount of optional coverage they initially chose.

Below are steps your plan member must take to add or change optional benefits.

- The member must complete the optional benefits section of the **Enrolment** form. They must also complete a **Health Statement**. (Please see **Submitting a Health Statement** on page 19.)
- If electing optional benefits for the first time, make sure the member nominates a beneficiary.
- The member must also complete and sign a non- smoking declaration form to confirm they're a non-smoker. This is required if your plan has smoker/non-smoker rates for Employee Optional Life. The member's spouse must do the same if they choose Spouse Optional Life.

Notes

- A **non-smoker** is a person who has not used tobacco within the past 12 months.
- A member or spouse must reconfirm their smoking status if they apply for more optional coverage.
- A member or spouse who first declared themselves as a smoker, then stops smoking, can request non-smoker status. They can do so by completing a non-smoking declaration.
- If we receive incorrect information about a non-smoking status we could reverse a claim for Optional Life.

Purchasing individual insurance when benefits end or reduce

A plan member and their spouse can apply to convert their group life insurance to a Sun Life individual policy. They can do so when their coverage ends, without having to give proof of good health. The member must send their written request for conversion to us within **31** days from the date their Life coverage ends, or is reduced. Your benefit plan will set out information about a plan member's conversion rights.

The plan member can also choose to buy our Choices products too. Group health and dental coverage can be transferred to our My Health Choice. Group critical illness can be transferred to our Choices Critical Illness Insurance (Choices CII) product. We also offer My Life Choice, as a less expensive alternative to the conversion product. The member will not have to give proof of good health if they apply within **60** days from the date their coverage ends. However, they will have to answer simple questions about their health.

You're responsible for letting eligible plan members know about their right to apply to convert their benefits, including:

- the 31-day period to convert their life insurance, and
- the 60-day period to buy Health Coverage Choice, Choices CII or My Life Choice

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

Please let the plan member know about these privileges as soon as possible. Be sure to do so after their benefits end or is reduced, so they don't miss the deadline.

Who to call

Plan members wanting to convert to individual life insurance or purchase Sun Life's Health Coverage Choice individual health and dental coverage can call **1 800 SUN-LIFE** (1-800-786-5433). Our call centre representatives will answer their call and ask for some personal and group plan information. The representative will then pass the information onto a Sun Life advisor. The advisor will then contact the plan member to discuss their insurance options.

Tax status of employer-paid premiums

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 (Canada)**	**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

We produce and mail premium billing statements to you each month. We'll also ensure any changes your plan members make after your bill is produced is shown on the following month.

Your 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 Chequing (PAC)

For your convenience, we also offer pre-authorized chequing (PAC) as an option. If you are interested in this payment method, complete the pre-authorized chequing form. This is posted on our website see **Administration and claim forms** section on page 32.

How we calculate premiums

We calculate premiums for complete months only.

Your premiums are not payable for the first month 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 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.

Submitting claims

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

Electronically at mysunlife.ca

- If you are set up for e-claims, plan members can submit certain claims at **mysunlife.ca**
- **Applicable to Extended Health Care, Dental, Health Spending Account, Personal Spending Account and disability claims**
- Plan members who download the **my Sun Life Mobile app** can submit and track their benefits claims there.

Dental: Dentists 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. Claims are received and processed fast.

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. Things like the deductible, or amounts over the plan limits. Claims are submitted immediately and processed fast.

Mail service

Plan members can mail completed Extended Health Care, Dental, Health Spending Account and Personal Spending Account claim forms. They can send 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. We must 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. The insurance industry has guidelines that all insurers use to determine which plan the claim should be sent to first. Here are the guidelines:

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

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

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

- The plan where the child is covered as an employee.
- The plan where the child is covered under a student health or dental plan provided through an educational institution.
- The plan of the parent with the earlier birth date (month/day) in the calendar year pays before the plan of the parent with the later birth date (month/day) in the calendar year (e.g. if the 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.

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

Note: Plan members cannot submit COB claims using their smartphone.

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

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

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

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

Extended Health Care

Extended Health Care benefits cover necessary medical expenses that aren't covered by provincial hospital and medical plans (see your group contract for more details). Plan members must submit a completed **Extended Health Care Claim form** for all medical expenses, other than expenses that are payable under a drug card program. They must submit this, with original receipts, to our group claims office address – shown on the claim form. We don't accept photocopies of receipts, except when the member is coordinating benefits with another plan, as outlined earlier. We recommend that members keep copies of all documents they send to us.

Hospitals normally submit claims for hospital expenses directly to us, and we pay the hospital directly. 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 your plan member claims expenses for a spouse or child, see the **Coordinating benefits with other plans** section on page 20.

Out-of-province medical expenses

To make a claim for emergency medical expenses, while travelling out-of-province, your plan member must:

- contact Allianz Global Assistance Service Canada Inc. (AZGA)* immediately
- follow the instructions in their Travel Benefit pamphlet (available at **mysunlife.ca**) to get their travel card and more

Note: Members who travel should keep their card with them at all times. They must call Allianz Global Assistance before they incur a medical emergency expense.

To claim non-emergency, out-of-province medical expenses, plan members must complete and submit an **Extended Health Care Claim form**, with their original receipts.

*AZGA is our travel assistance service provider.

Pay-direct drug plans

A pay-direct drug card helps us to simplify the prescription drug claim process. It also helps us to eliminate the use of claim forms. It reduces the plan member's out-of-pocket expenses.

Plan members can use drug cards to purchase eligible prescription drugs, only. Drug cards are accepted at most drug stores across Canada. Members can show their drug card to the pharmacist and if 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 or print extra copies for themselves.
- **my Sun Life Mobile:** Plan members who download the **my Sun Life Mobile app** can use their smartphone as a drug card.

Note:

- Plan members can only use their drug cards within Canada. If a member needs to fill a prescription while traveling, they can submit a paper **Extended Health Care Claim Form** when they return to Canada. We will assess the claim and convert the eligible expense amount to Canadian dollars.

When the drug card does not work at the pharmacy

Below are some of the most common reasons that drug cards are declined by a pharmacy.

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

If the plan member receives less than the amount they expected

A member may receive a benefit amount that is less than what is specified under your plan if:

- They have purchased a brand-name drug instead of a generic substitute. 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 costs 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 Extended Health Care Claim.

Dependent records must be up to date

We may decline claims if a plan member's dependent information isn't 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 had it stolen, they can get a new card from:

- **my Sun Life mobile app**
- **mysunlife.ca**
- your Group Client Services administration (notify your contact immediately)

Paper and mobile app drug cards are accepted by all participating pharmacies.

When a plan member leaves your company

When a plan member leaves your company, follow the normal process found on the Terminate a member page. Drug cards will no longer be accepted by pharmacies once the termination date is entered on the system. You should, therefore, have the plan member destroy their drug card(s) immediately.

Where to call

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

If a plan member contacts you with a problem, please have them contact our Customer Care Centre (CCC). They'll need to give us 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

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

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

Benefits include preventive and restorative dental treatment, in accordance with specific plan details, such as:

- deductibles
- co- insurance levels
- fee guides and maximums – as outlined in your group contract

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.

Members can follow these steps to submit a claim for Dental benefits:

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

Step 2 If the dentist hasn't sent the form to us, your plan member and the member's dentist will need to complete their respective parts of the **Dental Claim** form.

Step 3 Your plan member should submit the claim to us at the address shown on the form (if using a Sun Life claim form). They must also do so within the time limit specified in your group contract.

Plan members can find steps to claim expenses for a spouse or child in the **Coordinating benefits with other plans** section of this guide on page 20.

Getting an estimate

Plan members should ask their dentist to send us a fee estimate called a predetermination. This is for treatments over the amount specified in your contract. With this predetermination, we'll let the plan member and their dentist know which expenses (if any) will be covered. And we'll do so before the expense is incurred. This precaution allows the plan member to discuss treatment options with their dentist before the work starts. It also allows them to budget for the expense, if it's not covered by your plan.

Note: A predetermination is not a guarantee. In some situations, the amount of benefits paid may be different than the amount that was approved. For example, if the claimant has other work done in the meantime, that could bring them over the annual coverage maximum. The amount paid may also be different if the work done is different from the work outlined in the dentist's estimate.

Orthodontic claims

We'll repay members as expenses are incurred. We'll pay about one-third of the full eligible treatment cost, for the initial payment.

Health Spending Account Guide

Please refer to our Health Spending Account Administration Guide, if relevant to your plan. It's available on the SunAdvantage Forms page.

Personal Spending Account Guide

Please refer to our Health Spending Account Administration Guide, if relevant to your plan. It's available on the SunAdvantage Forms 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.

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

Your plan member can submit each part of the claims forms separately, as they're completed. We must receive claim forms within the time limits indicated in your contract.

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 that the plan member was able to work (and doesn't qualify for benefits), the member should return the 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 to fill out the relevant claim forms. Then, send them to us six to eight weeks before the start of the Long Term Disability payments.

Notes:

- If a plan member is covered by Sun Life for both Long Term Disability and Life benefits, we'll assess the waiver of premium claim for the Life benefit. This is done at the same time we assess 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 qualify for waiver of premiums.

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.

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 department 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.

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.

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

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).

Note:

- Plan administrators should avoid giving an opinion on how the will is to be applied. Once we review a copy of the will, we 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.

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

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

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

How proceeds are paid

We 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.

Note:

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

Criminal offence

If the beneficiary is charged with a criminal offence related to the death claim, we 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.

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.

Notes:

- If a member has nominated an irrevocable beneficiary the member will require their consent to apply for this benefit.
- If a member is within five 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 representative to discuss the possible financial implications to your contract.

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.

Plan Sponsor Services – Group Benefits Administration Option

Interested in a simpler, more convenient way to manage your group benefits program? Our customer- driven GBA web-based tool lets you handle the fundamental aspects of your group benefits program. GBA removes the paperwork that slows things down. It also makes record-keeping quick and easy. What's more, it puts information at your fingertips when you need it.

With our GBA web-based tool, you can:

- enrol plan members, update their records, terminate and/or reinstate their coverage
- generate, print and/or save Coverage Summaries and drug cards(if applicable) for plan members
- view the details of your benefit plan's coverage and plan set-up
- download and print/save your Contract, Focus Updates, Benefit booklets and other plan documents
- download and print a wide range of standard guides and forms for administration
- view and print a monthly premium statement at your convenience

Flexible Security

Security is critical when you're using the Internet to administer your benefit plan. We keep your data secure and confidential with:

- Strong encryption
- Firewalls
- A high level of physical security at our server site

You also have the flexibility to tailor security levels to suit your needs. For example, you can choose to limit plan administrators' access. That way, they can only see data or conduct transactions for plan members in their location.

All you need

1. Windows 10 or higher

2. 128 bit encryption

3. Microsoft Adobe Acrobat Reader 8.0 or higher

4. The latest browser version with all the applicable security patches installed (We recommend this for improved security, performance and support.)

5. 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

6. A plan sponsor Access ID and Password

If you are interested in this option of administering your Group Benefits plan, please contact your Client Service Administrator for more information (see **Contact information** section on page 33).

Administration and claim forms

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

You can also access forms without an Access ID or password. Follow these steps to do so:

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
7	Naming a Beneficiary	Updating beneficiary information
		The Sun Life digital beneficiary tool
8	Using the Sun Life Digital Beneficiary tool	New section added
8-9	Electronic beneficiary (e-beneficiary, electronic signatures), and Scans	New section added
30	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

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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Toronto, Ontario M5K 1G8
416-777-2221 www.clhia.ca

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79, rue Wellington Ouest, bureau 2300
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416-777-2221 www.accap.ca

Contact information

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

Visit our website at **mysunlife.ca** to find useful contact information, and other information you may need.

You can reach SunAdvantage Client Services at:

Phone number:
1-877-786-7227

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

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

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

Web site address:
sunlife.ca/smallbusiness

Hours of operation:
8:30 a.m. – 4:30 p.m. EST
Eastern, Ottawa and Central Region
9:30 a.m. – 6:30 p.m. EST
Western

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