

# SunAdvantage Administration Guide

for Sun Life Financial-administered group plans



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

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



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Group Benefits are provided by Sun Life Assurance Company of Canada, a member of the Sun Life Financial group of companies.



# Introduction

As a plan administrator, you have an important role to play. This guide is designed to help you. It describes the procedures to be followed in the day-to-day administration of your plan and should be used in conjunction with your group contract. We also provide the following companion guide, if applicable to your plan.

- Health Spending Account Administration Guide

A key part of your role is to provide us with all necessary plan member information on a timely basis so we can pay claims and calculate your benefit premiums. All plan member data, including beneficiary designations, is stored on our administration and claims systems. Changes in plan member records such as earnings, coverage and dependent status should be immediately reported to us. You should retain copies of all information you send.

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

**Note:**

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

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

## Protecting members' privacy

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

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

Our privacy policy and code for our Canadian operations can be found on our website at [www.sunlife.ca](http://www.sunlife.ca).



# Types of plans and effective dates

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

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

## Determining effective dates

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

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

## Participation Level of 100% (mandatory benefit plan)

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

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

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

If you receive the enrolment form . . .	Then the effective date is . . .
<ul style="list-style-type: none"> <li>On or before the date the plan member becomes eligible</li> </ul>	<ul style="list-style-type: none"> <li>The date the plan member becomes eligible</li> </ul>
<ul style="list-style-type: none"> <li>Within 31 days of the date the plan member becomes eligible</li> </ul>	<ul style="list-style-type: none"> <li>The date the <i>Enrolment form</i> is received</li> </ul>
<ul style="list-style-type: none"> <li>More than 31 days after the date the plan member becomes eligible. The member is considered a late applicant. The member and eligible dependents must complete a <i>Statement of Health</i> form to verify proof of good health.</li> </ul>	<ul style="list-style-type: none"> <li>The date the <i>Statement of Health</i> form is approved. There may be a restricted maximum for Dental). We will notify you in writing whether the application is approved.</li> </ul>

## About RAMQ

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

## Combined mandatory and non-mandatory plans

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



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

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

### When a member refuses coverage

<p><b>As a result of comparable coverage:</b></p> <ul style="list-style-type: none"> <li>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.</li> </ul>	<p><b>Other than for comparable coverage:</b></p> <ul style="list-style-type: none"> <li>Mandatory plan – Members cannot refuse coverage if the plan is mandatory.</li> <li>Non-mandatory plan – A member may refuse all coverage, or all dependent coverage, but members cannot pick and choose benefits.</li> </ul>
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\*The most common type of comparable coverage is a spouse's plan. However, a member could also be covered under another group plan as an active employee or a retiree.

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

**Note:**

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

### Reinstating a former plan member

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

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

### If your plan has optional benefits

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



# Enrolling in the plan

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

## The Enrolment Envelope

- Step 1 Complete the first section of the *Enrolment form* included in the Enrolment Envelope for each plan member.
- Step 2 Provide the Plan Member the Enrolment Envelope and have the plan member complete the remaining sections and return to you.
- Step 3 Review the form to ensure it is fully completed and signed by the plan member.
- Step 4 Make a copy of the completed *Enrolment form* and send the original to SunAdvantage Client Services (see **Contact information** section).
- Step 5 You will receive a *Member Change Form* 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 Envelope provides the member a benefit booklet and other documentation pertinent to the plan coverage.

### Note:

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

## More on the Enrolment form

Positive enrolment data: (detailed dependent information is entered on our claims system for validating claims eligibility), the spouse details and children details section of the *Enrolment form* must also be fully completed.

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

If your plan has Optional Life with smoker/non-smoker rates, advise the plan member to complete the non-smoking declaration (to confirm whether they are a smoker) if electing Employee Optional Life. The spouse must also complete the non-smoking declaration if Spouse Optional Life is elected.

### Note:

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

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.)



## When proof of good health (*Statement of Health* form) is required

A *Statement of Health* 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 is applying for Optional Life benefits or other voluntary 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 25 per cent of existing coverage, or \$500 per month, whichever is greater.

## Submitting a *Statement of Health* 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 *Statement of Health* form is highly confidential. Advise the plan member to send the completed form directly to us. Mailing instructions are provided on the form.
- Step 4 We will notify you and the plan member of our decision.
- Step 5 If approved, we will update the plan member record on our system.

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

**If the application is approved:** A confidential letter will be sent to the plan member advising of our decision. The coverage will be effective on the date of approval and premiums charged accordingly.

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

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

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





# Naming a beneficiary

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

**Note:**

- When a member nominates their beneficiary(s), you should ensure that they are not changing a previous nomination of an irrevocable beneficiary. (Please see further details on irrevocable beneficiaries below.)

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

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

## Revocable and irrevocable beneficiaries

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

*Irrevocable beneficiary* means the member cannot change the designation without meeting specific requirements. A beneficiary designation may be irrevocable for the following reasons:

- Irrevocable by provincial law — In the province of Québec, a legally married spouse or civil union spouse designated as the beneficiary is presumed to be irrevocable unless specified as revocable. If the revocable box on the *Enrolment form* or *Beneficiary Nomination form* is not checked off, the designation is irrevocable.
- Irrevocable at the member's request — If a member wishes to voluntarily designate a beneficiary as irrevocable, they simply write the word "irrevocable" on the beneficiary nomination itself; for example, "John Doe, Spouse, Irrevocable".
- Irrevocable by court ruling — A beneficiary designation could be made irrevocable by a court ruling. For example, a term of a divorce decree may require that the spouse must remain as the beneficiary and cannot be changed without the spouse's consent. The document issued by the court should be kept with the beneficiary nomination for future reference.

## Changing a beneficiary designation

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

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

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



## More about beneficiary designations

Event	Additional information
If your plan has Optional Life benefits	<p>The member may designate separate beneficiaries for Basic Employee Life, Optional Employee Life and Spouse Optional Life. The member needs to complete each of the applicable sections of the <i>Enrolment form</i> or <i>Beneficiary Nomination</i> form. This is true even if the member wishes to designate the same beneficiary for basic and optional benefits.</p> <p>Ensure that the member does not designate their spouse as beneficiary for Spouse Optional Benefits.</p>
Designating one beneficiary	To designate one beneficiary, the member must complete the name and relationship of the beneficiary and indicate 100 per cent on the percentage area of the form.
Designating more than one beneficiary	To designate more than one beneficiary, the member must complete the name and relationship and percentage on the form for each beneficiary. The total of the designated percentages must equal 100 per cent.
Appointing a contingent beneficiary	<p>To appoint a contingent beneficiary, the member should complete the Contingent Beneficiary section of the <i>Enrolment form</i> or <i>Beneficiary Nomination</i> form.</p> <p>(A contingent beneficiary is the person designated to receive the proceeds if the primary beneficiary dies before the insured.)</p>
Designating a minor child	To designate a minor child, the member must designate a trustee in all provinces except Québec. In Québec, a trustee is not legally required, but if there is one, a trust must be established by a separate trust agreement or in a will.
Designating an estate	<p>A member designating the estate as beneficiary should consider the following:</p> <ul style="list-style-type: none"> <li>• The insurance proceeds may be subject to estate taxes.</li> <li>• Insurance proceeds payable to the estate are subject to claims from creditors, whereas proceeds payable to a named beneficiary may be protected from creditors.</li> <li>• Probate costs vary from province to province and are based on the total value of the estate. These costs are not incurred if proceeds are payable to an individual beneficiary.</li> </ul>
When no beneficiary has been designated	Proceeds will be paid to the member's estate. A properly constituted and current will should be submitted with any claim to avoid delays in processing.

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

Beneficiary dies before the member AND equal beneficiary percentages were assigned.	If the beneficiary percentages are equal and if one beneficiary dies before the member then his/her share would be paid in equal shares to the surviving beneficiaries.
Beneficiary dies before the member AND different beneficiary percentages were assigned.	<ul style="list-style-type: none"> <li>If the beneficiary percentages are not equal and if one beneficiary dies before the member, then his/her share would be paid to the member's estate.</li> <li>If that share should be divided equally between the remaining beneficiaries, the member should add the following notation on the form: "In the event of the death of one or more of the above named beneficiaries, his/her share is to be divided equally between the surviving beneficiaries."</li> </ul>

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

**Beneficiaries in Québec**

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

Current beneficiary designation	Can be changed to
Spouse designated on or after 20/10/76 if indicated as revocable on the enrolment form	Any beneficiary
Spouse designated on or after 20/10/76 – stipulates that designation is irrevocable, OR does not stipulate that it is revocable	Cannot be changed unless: <ul style="list-style-type: none"> <li>A waiver was signed;</li> <li>Divorce was granted on or after 20/10/76 and before 1/12/82 terminating the spouse's rights, or</li> <li>Divorce was granted on or after 1/12/82</li> </ul>
Husband designated on or after 1/7/70 but before 20/10/76 with or without revocability stipulation	Any beneficiary
Husband designated on or after 1/7/70 but before 20/10/76 with irrevocability stipulation	Cannot be changed unless: <ul style="list-style-type: none"> <li>A waiver was signed</li> <li>Divorce granted on or after 20/10/76 and before 1/12/82 terminating the husband's rights, or</li> <li>Divorce was granted on or after 1/12/82</li> </ul>
Husband designated before 1/7/70	Any beneficiary
Wife designated before 20/10/76, and divorce granted before 20/10/76	Any beneficiary
Wife designated before 20/10/76, but divorce granted on or after 20/10/76 but before 1/12/82	Child until 20/10/77; otherwise wife's designation is irrevocable except if she waived her right or if divorce terminated her rights



# Maintaining plan member records

It is very important that plan member information is kept up-to-date at all times. This ensures that your monthly premiums are calculated based on the most recent changes, and that claims are paid quickly and accurately.

## Recording plan member changes

Changes are typically recorded on the *Member Change Form*.

**Important:** The *effective date* must be shown for all changes affecting a member's coverage such as:

- Salary changes,
- 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 Member informs you when a record change is required (e.g. new spouse).

Step 2 You record the change on the *Member Change Form* and send to us by mail, fax or e-mail.

Step 3 We update our systems to reflect the change.

Step 4 We send you an updated *Member Change Form*. You will also receive a new wallet ID card for the plan member if the information on the wallet ID card has changed.

Step 5 You verify the updated *Member Change Form* to ensure the information was accurately updated.

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

### Note:

- When a plan member record is changed in our administration system, the new data is transferred to our claims system overnight and to our Pay-Direct drug system the following night. If claims are processed during this period, they will not reflect the new data.



### Change from single to family status

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

- **Mandatory benefit plan**

The change effective date is the date of the plan member’s status change, i.e. date of marriage, adoption, birth of a child, etc.

- **Non-mandatory benefit plan**

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

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

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

Positive enrolment data: (all dependent information is entered into our system and used to validate claims eligibility), be sure to send us new dependent information as soon as possible to avoid claims being delayed or rejected.

### Updating student information

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

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

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

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

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



## Adding coverage that was initially refused due to comparable coverage

Event	Mandatory plan	Non-mandatory plan
Other coverage ends (e.g. spouse's plan)	Coverage start date should be the day after the other coverage (e.g. spouse's plan) ends	<ul style="list-style-type: none"> <li>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.</li> <li>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 <i>Statement of Health</i> form to verify proof of good health. There may be a restricted maximum for Dental.</li> </ul>
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 the member's eligible dependents must complete a <i>Statement of Health</i> form to verify proof of good health. There may be a restricted maximum for Dental.

## Terminating coverage

Coverage terminates 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 to an individual insurance policy. (See **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, depending on the benefit. You do not have to notify us of age-related changes, as our system will automatically process the change at the appropriate date. You do need to advise us if there are any changes to coverage as a result of retirement.

The member and spouse are eligible to apply to convert their life coverage to an individual policy when coverage reduces or terminates. (See **Purchasing individual insurance when benefits end or reduce** section.)

## Changing a beneficiary designation

A *Beneficiary Nomination* form needs to be completed, dated and signed by the plan member then sent to us so that we can update our systems. (See **Naming a beneficiary** section.)

## Plan members who are approved for disability

We will 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 has been approved.



## Maternity/parental leave

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

### Continuing coverage during a leave

- You do not need to notify us if all coverage is continuing for the province's legislated maternity/parental leave period.
- You must notify us if optional benefits are terminating. The cancellation of the optional benefit will be treated as a refusal, and a *Statement of Health* is required in order to re-elect the benefit.

### 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.
- You must notify us of the termination.

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

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

### About RAMQ:

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

## If a plan member dies

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

Follow the instructions in the **Submitting Claims** section to submit the Life claim.



## Adding or changing Optional Life benefits

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

- The member must complete the optional benefits section of the *Enrolment form and a Statement of Health* form must also be completed. (See *Submitting a Statement of Health* form.)
- If electing optional benefits for the first time, make sure that the member nominates a beneficiary.
- If your plan has smoker/non-smoker rates, the member must also complete and sign a non-smoking declaration (to confirm whether they are a non-smoker) if they elect Employee Optional Life. The spouse must do so if Spouse Optional Life is elected.

### Notes:

- A *non-smoker* is a person who has not used tobacco within the past 12 months.
- A member or spouse must re-declare their smoking status if they apply for additional optional coverage.
- A member or spouse who has declared themselves a smoker and later stops smoking can request non-smoker status by completing a non-smoking declaration.
- Inaccurate information about the non-smoking status of the member or spouse may invalidate a claim for Optional Life.





# Purchasing individual insurance when benefits end or reduce

When group benefits end or reduce, the plan member and/or spouse can apply to convert the terminated group Life amount to a Sun Life Financial individual life insurance policy without having to provide proof of good health. The written request for conversion must be submitted to us within 31 days from the date the Life coverage ends or reduces.

The plan member also has the option to purchase our Health Coverage Choice individual 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.

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 life insurance, and
- Informing the plan member of the 60-day period to purchase Health Coverage Choice.

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

## Who to call

Plan members who would like to convert to individual life insurance or purchase Sun Life Financial's Health Coverage Choice individual health and dental coverage should call 1 800 SUN-LIFE/1-800-786-5433. A call centre representative will ask for some personal and group plan information (shown on the *Insurance options for plan members on termination of group benefits* form) and forward it to a Sun Life Financial advisor, who will contact the plan member to discuss available options.



# Tax status of employer-paid premiums

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

Here is a quick overview of which employer-paid premiums are considered taxable and the basis for the calculations. This information is not intended to provide tax advice. **We recommend that you consult a tax advisor about calculating taxable group benefits.**

	Income Tax Act (Canada)	Income Tax Act (Québec)*
Employer-paid premiums that are taxable	Employer-paid premiums and related sales tax on group life insurance are taxable benefits for current and former employees.	Employer-paid premiums and sales tax for group life insurance; private health services plan benefits (such as medical, dental, health spending account); and other group insurance, such as AD&D are taxable benefits for current, past and future employees who live or work in Québec.
Employer-paid premiums that are not taxable	Employer-paid premiums for accident (AD&D), private health services plan benefits (such as medical, dental and health spending account) and disability benefits are not considered taxable benefits.	Employer-paid premiums for disability benefits are not considered a taxable benefit.
Taxable benefit calculation	The taxable benefit is determined as: Total premiums and related sales tax LESS Premiums and related sales taxes paid by the employee	The taxable benefit is determined as: Total premiums and related sales tax paid for the employee's <i>coverage</i> (e.g. individual, single-parent or family coverage) and <i>benefits</i> (e.g. medical, hospital or dental) LESS Premiums and related taxes paid by the employee and premium refunds (dividend, returns or refunds) received during the year with respect to the employee's coverage and benefits

\* The information provided in this table regarding members who reside or work in the province of Québec is to be used only by Sun Life Financial customers who have entered into an insurance contract with us. Plan sponsors with an ASO (administrative services only) arrangement with Sun Life Financial and that have members in Québec, should refer to the Revenu Québec website for taxable benefit information and requirements at <http://www.revenu.gouv.qc.ca/eng/ministere/index.asp>.

Canada Revenue Agency (CRA) establishes what group benefits must be included as income as defined under the Income Tax Act (Canada). You can find a comprehensive list of these benefits at <http://www.cra-arc.gc.ca/menu-e.html>.



Revenu Québec establishes what group benefits must be included as income for current, past and future employees who work or reside in Québec. You can find a comprehensive list of these benefits at <http://www.revenu.gouv.qc.ca/eng/ministere/index.asp>.



# Premiums

Premium billing statements are produced and mailed to you each month. Any member changes processed after your monthly bill has been produced will be reflected on your next month's statement.

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

## Pre-Authorized 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 posted on our website (see [Administration and claim forms section](#)).

## 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.



# Submitting claims

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

## Internet and electronic

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

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

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

If they lose their card or need extra copies for family members, plan members can print paper drug cards from our Plan Member Services website. You may also choose to have plan members print paper drug cards as a convenient, cost-effective alternative to distributing plastic cards. (Our paper cards are accepted by all participating pharmacies.)

## Paper – mail

Plan members can mail completed Extended Health Care, Dental and Health Spending Account claim forms, along with their original receipts, to the claim office nearest them. Personalized claim forms can be downloaded from our Plan Member Services website.

Claims are assessed based on the information that you or your plan members send to us, so it is important to ensure that our records are up to date and that all claim forms are fully completed and received within the time limits specified in your contract.

## Coordinating benefits with other plans

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

**Plan member's expenses:** The plan under which the plan member is covered as an employee pays first. If a member has coverage through different employers:

- The plan where the member is an active, full-time employee pays first,
- The plan where the member is an active part-time employee pays second, and
- The plan where the member is a retiree pays last.

**Spouse's expenses:** Where a plan member is also covered as a dependent under his or her spouse's plan:

- The plan where the employee is a member pays first, and
- The plan where the employee is covered as a spouse pays second.



### Dependent children's expenses:

- The plan of the parent with the earlier birth date (month/day) in the calendar year pays first (e.g. if the member's birthday is in June and the spouse's birthday is in March, the spouse's plan pays first).
- 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 pays first.
- If the parents are separated or divorced, the following plans pay in the order that they appear:
  - 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 priority cannot be established in the above manner, the benefits will be prorated in proportion to the amount that would have been paid under each policy had there been coverage under only that policy.

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

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

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

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

## 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 group contract.) For all medical expenses other than drug expenses payable under a drug card program, plan members must submit a completed *Extended Health Care Claim Form*, along with original expense receipts to our group claims office address shown on the claim form (photocopies of receipts are not accepted, except where the member is coordinating benefits with another plan, as outlined above). Members should keep copies of all information they send us.

Claims for hospital expenses are normally submitted directly to us by the hospital, and we pay the hospital directly. The member receives a claim statement from us showing what was claimed and paid.

**Note:** Members should check their claim statement to ensure they actually received the services being claimed.



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

## Out-of-province medical expenses

To make a claim for emergency medical expenses while travelling out-of-province, the plan member must contact Europ Assistance USA, Inc., our travel assistance service provider, immediately and follow the instructions in their Travel Benefit pamphlet. (These pamphlets are available from your Sun Life Financial service representative, or members can print one directly from our Plan Member Services website.) To claim non-emergency, out-of-province medical expenses, members should complete an *Extended Health Care Claim Form* and submit it to our claims office along with original receipts.

## 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 will be sent to you within about 10 working days from the date the member is added to our system. We provide one card if the member has single coverage; two cards are automatically provided if the member has family coverage. All cards are issued in the member's name. Contact your Group Client Services administration contact if an extra card is required for an overage dependent child.

### Note:

- We will automatically issue a new drug card(s) when a member's last name or member ID number changes, or when coverage changes from single to family.

Plan members can also print personalized paper drug cards from our Plan Member Services website. Our paper drug cards are accepted by all participating pharmacies.

Drug cards are used to purchase prescription drugs only. They are accepted at most drug stores across Canada. Plan members simply show their drug card to the pharmacist, and provided the drug is eligible, will pay only the amount not covered by the plan (e.g. the deductible or amounts over the plan limits).

### Note:

- Drug cards can only be used within Canada. If a member needs to purchase a prescription while traveling, they should submit a paper *Extended Health Care Claim Form* on their 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

These are some of the most common reasons that drug cards are declined:

Issue	Solution
Incorrect date of birth is entered	<ul style="list-style-type: none"> <li>• 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 the system, the claim will be declined.</li> <li>• Plan members should ask the pharmacist to check if the correct date of birth was entered. If it was and the claim is still rejected, check to see what date of birth is recorded on our system. Process a change to correct it if necessary.</li> <li>• 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.</li> </ul>



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 pay or	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 plan, depending on your plan design. The pharmacist can contact the doctor to see if a therapeutically equivalent drug (that is covered) can be prescribed.

### If the plan member receives less than the amount they expected

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

- They have purchased a brand-name drug instead of a generic substitution, and your plan covers only up to the cost of generic drugs.
- The pharmacy charges more than the "reasonable and customary" limit typically charged in their regional area for dispensing fee or ingredient costs. ("Reasonable and customary" limits are applied on a number of expenses to ensure your plan does not incur unnecessary cost when providers charge excessive fees.)

### Maximum drug supply covered at one time

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

### Items that cannot be purchased with the card

There may be some drug expenses covered under your plan that cannot be purchased using the drug card. See your contract for a list of these items. The member will need to pay the pharmacy for these expenses and submit a paper claim using the *Extended Health Care Claim Form*.

### Dependent records must be up to date

If your plan has positive enrolment (detailed dependent records maintained on our system to validate claims), claims will be declined if the dependent information has not been set up on our system.

You are responsible to determine that overage dependent children continue to meet your plan's eligibility requirements (e.g. must be a full-time student or disabled and financially dependent on the member), and advise us when their coverage terminates.

### Lost or stolen cards

If a plan member loses their drug card or it is stolen, notify your Group Client Services administration contact immediately and request a replacement card.

### When a plan member leaves your company

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





## Where to call

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

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

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

To submit a claim for Dental 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 send the form to us at the address shown on the form (if using a Sun Life Financial claim form) within the time limit specified in your group contract.

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

### Getting an estimate

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

This is a precaution to allow the claimant to discuss treatment options with the dentist before the work begins and 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 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).

### Orthodontic claims

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

## Health Spending Account

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



## Disability

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

Short-Term Disability and Long-Term Disability claim forms come in three parts:

- The plan member statement, which must be completed by the plan member,
- The attending physician statement, which must be completed by the doctor supervising the plan member's treatment, and
- The plan sponsor statement, which must be completed by you, the plan administrator.

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

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

To submit a claim for Long-Term Disability benefits or for waiver of premiums under the Life and Accidental Death & Dismemberment benefits, ensure the appropriate claim forms are completed and sent to us six to eight weeks prior to the commencement of the Long-Term Disability payments.

### Notes:

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



## 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 Life Claims Department.

### Partial (advance) payment immediately upon death

Where the beneficiary is a family member (e.g. a spouse) and has an immediate need for funds, a partial claim payment (of up to \$10,000) can be made (within 24 hours) before death claim forms are submitted. This is intended to help the family deal with immediate financial issues such as outstanding debts.

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

We require the following information to issue partial advance payments:

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

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

- *Notification of Death* form (see below),
- *Election of method of settlement and statement of claim form* (see below), and
- The original *Enrolment form* and any subsequent *Beneficiary Nomination* forms.
- For an Optional Life insurance claim, we require:
  - The original approval notice Sun Life Financial issued confirming approval of the member's application for Optional Life insurance, and
  - A completed *Physician's statement* section on the *Election of method of settlement and statement of claim form* if the death occurred within two years of coverage being approved.

#### 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, section/division number and class. You must sign and date this form to verify coverage.

## 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 is within five years of a scheduled termination they are not eligible for the program.
- Before requesting a Living Benefits loan, you should contact your Sun Life Financial 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, subject to the terms of the contract that were in effect on the date the member became disabled, including reductions and terminations. Where Sun Life Financial provides the Life benefit but not the Long-Term Disability benefit, we require the following information in order to assess the Waiver of Life Premium claim:

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

### Accidental Death & Dismemberment and Critical Illness Insurance

To make other types of claims (e.g. if your plan includes Accidental Death & Dismemberment benefits, or Critical Illness Insurance) contact your Sun Life Financial service representative, and we will provide you with the information and the appropriate claim forms.



# Plan Sponsor Services Administration Option

Interested in a simpler, more convenient way to manage your group benefits program? Our customer-driven Web-based tool lets you handle the fundamental aspects of your group benefits program. Plan Sponsor services eliminates the paperwork that slow things down, make record keeping quick and easy, and puts information at your fingertips when you need it.

With our Web-based Plan Sponsor Services you can:

- enrol plan members, update their records, terminate and/or reinstate their coverage;
- generate and print Coverage Summaries for plan members;
- view the details of your benefit plan's coverage and plan set-up;
- download and print a wide range of standard forms for administration;
- print paper Pay-Direct drug cards (or encourage plan members to do so using our Plan Member Services Web site) if they lose their plastic card or need more cards for family members if applicable; and
- 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. Strong encryption, firewalls, and a high level of physical security at our server site are some of the ways to keep your data secure and confidential. At the same time, you have the flexibility to tailor security levels. For example, you can choose to limit plan administrators' access so they can only view data or conduct transactions for plan members in their particular location.

## All you need

To administer your group benefits through Plan Sponsor Services, you will need:

1. *Windows 2000 or higher*
2. *An internet connection with adequate performance (56 KB modem or higher)*
3. *Internet Explorer 6.0 or Netscape 7.0 or higher*
4. *Microsoft Adobe Acrobat Reader 7.0 or higher*
5. *128-bit encryption*

If you are interested in this option of administering your Group Benefits plan please contact your Customer Service Representative for further information (see **Contact information** section).



# Administration and claim forms

To help you with the administration of your plan, some of our standard forms have been posted on our public website at [www.sunlife.ca](http://www.sunlife.ca). You can access them without an Access ID or password.

Step 1 Go to our website at [www.sunlife.ca](http://www.sunlife.ca)

Step 2 Select "Plan Sponsor"

Step 3 Select "Small Business Benefits"

Step 4 Select "Download Forms" (a list of forms will be displayed and are available to download and print)



# Contact information

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

Visit our website at [www.sunlife.ca](http://www.sunlife.ca) to find useful information and contact information.

## SunAdvantage Client Services can be reached at:

Hours of operation:

8:30 AM - 4:30 PM EST Eastern, Ottawa, and Central Regions

9:30 AM - 6:30 PM EST Western Region

Phone number: 1-877-786-7227

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

Mailing address:

Sun Life Assurance Company of Canada

SunAdvantage Department

PO Box 11010 Stn CV

Montreal QC H3C 4T9

Courier:

Sun Life Assurance Company of Canada

SunAdvantage Department

1155 Metcalfe St

Montreal QC H3B 2V9

Web site address: [www.smallbusiness.sunlife.ca](http://www.smallbusiness.sunlife.ca)



