Plan Sponsor Services

SunAdvantage Group Benefits Administration guide

Published June 2020

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

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

Life's brighter under the sun

Sun Life

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Introduction to Plan Sponsor Services

Tips:

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

Do not share your Access ID or password with anyone. They're key elements of our web security, created to protect you and your plan members' information.

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

With our Plan Sponsor Services website, you can:

- enroll plan members, update their records
- terminate or reinstate plan members' coverage
- view, print or save plan members' coverage summaries and drug cards (if applicable)
- view details of your benefits plan coverage and set-up
- download Client contracts, booklets and plan documents
- download and print a wide range of standard forms for benefits administration
- view and print a monthly premium statement

To use our Plan Sponsor Services website, you'll need:

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

Your Access ID and Password

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

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

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

When you receive your Plan Sponsor Access ID and password, go to sunlife.ca/sponsor. Then, enter this information in the correct fields and click **Submit**.

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

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

Benefit Summary

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

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

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

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

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

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

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

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

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

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

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

Protecting plan members' privacy

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

Our privacy policy and Privacy Code for Canada includes obligations related to the appropriate collection, use and disclosure of personal information. We don't release Confidential plan member medical information to:

- plan sponsors
- doctors
- plan members' workplace medical or health centre staff
- legal representatives, etc.

We also don't release plan member medical information without the consent of the plan member. Even then, we'll only do so under certain circumstances. As administrator of your benefits plan, you may need to handle documents that contain 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 your day-to-day administration activities.

Tips:

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

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

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

- Store all member information in a safe place.

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

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

You can find our privacy policy and code for our Canadian operations on our website at **sunlife.ca**.

Getting started

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

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

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

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

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

Member information

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

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

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

About effective dates

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

Tips

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

Types of plans and effective dates

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

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

Determining effective dates

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

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

Participation Level of 100% (mandatory benefit plan)

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

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

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

If you receive the enrolment form ...	Then the effective date is ...
• On or before the date the plan member qualifies for coverage	• The date the plan member qualifies
• Within 31 days of the date the plan member becomes eligible	• The date the plan member signs the Enrolment form
• More than 31 days after the date the plan member becomes eligible: The plan member is considered a late applicant. The plan member and eligible dependents must complete a Health Statement form to verify proof of good health.	• The date we approve the Health Statement (there may be a restricted maximum for Dental). We'll let you know, in writing, if/when we approve the application.

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 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.

Note:

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

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

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

When a member refuses coverage

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

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

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

Reinstating a former plan member

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

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

If your plan has optional benefits

Your plan may include optional benefits such as Optional Life and Optional Accidental Death & Dismemberment. Some optional benefits require proof of good health and a Health 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 benefits booklet for details available within the Contract & documents page).

Enrolling in the plan

Notes:

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

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

The Enrolment Guide

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

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

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

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

Step 5 File in your member records file.

Please note the Enrolment Guide provides the plan member:

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

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

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

More on the Enrolment form

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

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

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

Notes:

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

When proof of good health (Health Statement) is required

A Health Statement is required when:

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

Submitting a Health Statement form

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

Step 2 Advise the plan member to answer all questions on the form to ensure coverage is not delayed. 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.

Step 4 We will let you and your plan member know what we decide.

Step 5 If we approve your plan member's application, we'll update the member's record on our system. And a confidential letter will be sent to the plan member advising them. You will then be able to go to the View a member page to save and/or print a new copy of their coverage summary and drug card(if applicable).

Until you receive written confirmation from us that the plan member's application has been approved for the amount of coverage requested, do not make payroll deductions or remit premium for the coverage under review. If approved, the coverage will be effective on the date of approval and premiums charged accordingly.

If the application is 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 close.

Naming a beneficiary

Notes:

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

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

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

Revocable and irrevocable beneficiaries

Revocable beneficiary means that the plan member is free to change the beneficiary designation at any time. We assume a beneficiary is revocable, unless they're specifically designated as irrevocable. This applies in all provinces, except in Québec.

Irrevocable beneficiary means the plan member cannot change the designation unless they are:

- **Irrevocable by provincial law:** A legally married spouse or civil union spouse designated as the beneficiary is presumed to be irrevocable in the province of Québec. To make the beneficiary revocable, the plan member must check off the revocable box on the Enrolment form or Beneficiary Nomination form.
- **Irrevocable at the member's request:** If a member voluntarily chooses to designate a beneficiary as irrevocable, they can just write the word "irrevocable" on the beneficiary nomination. For example, "John Doe, Spouse, Irrevocable."
- **Irrevocable by court ruling:** A court ruling can make a beneficiary designation irrevocable. For example, a term of a divorce decree may require that the former spouse remain as the beneficiary. You should keep the document issued by the court with the beneficiary nomination, for future reference.

Changing a beneficiary designation

If the beneficiary designation is revocable, the member must complete, date and sign a Beneficiary Nomination form.

If the beneficiary designation is irrevocable, the member must complete, date and sign a Beneficiary Nomination form. 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, to revoke their rights
- Final Decree of Divorce (see the table below Beneficiaries in Quebec)
- Proof of death of the irrevocable beneficiary.

More about beneficiary designations

Event	Additional information
If your plan has Optional Life benefits	• The member may designate separate beneficiaries for Basic Employee Life, Optional Life and Spouse Optional Life. • The member needs to complete each of the applicable sections of the Enrolment form or Beneficiary Nomination form. This is true even if the member wishes to designate the same beneficiary for basic and optional benefits.
Designating one beneficiary	• To designate one beneficiary, the plan member must specify the name and relationship of the beneficiary. • The member must write 100% in the percentage area of the form.
Designating more than one beneficiary	To designate more than one beneficiary, the member must complete the name, relationship, and percentage on the form for each beneficiary. The total of the designated percentages must equal 100 per cent.
Appointing a contingent beneficiary	The member should complete the Contingent Beneficiary section of the **Enrolment form** or **Beneficiary Nomination form** to appoint a contingent beneficiary. (A contingent beneficiary is the person designated to receive the proceeds if the primary beneficiary dies before the insured.)
Designating a minor child	• The member must appoint a trustee in all provinces, except Québec, to designate a minor child. • A trustee is not legally required in Quebec. (If the member does designate a trustee, they must es-tablish a separate trust.
Designating an estate	A member designating the estate as beneficiary they should bear in mind that: • the insurance proceeds, may be subject to estate taxes. • Insurance proceeds payable to the estate are subject to claims from creditors. These proceeds may be protected from creditors if they're payable to a named beneficiary. • Probate costs vary from province to province and are based on the total value of the estate. These costs are not incurred if proceeds are payable to an individual beneficiary.
When no beneficiary has been designated	• Proceeds would go to the member's estate. Note: A properly constituted and current Will should be submitted with any claim to avoid delays in processing.

Other things to consider:

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

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

Beneficiaries in Quebec

The following table was prepared by the Canadian Life and Health Insurance Association Inc. (CLHIA). It will help you answer questions about beneficiary designations for Québec members. And, it will help you understand when a beneficiary change is allowed.

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

Maintaining plan member records

Notes:

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

- Once updates to the plan member record have been made, an updated coverage summary and link to drug card (if applicable) will automatically be generated which can be downloaded and/or printed and distributed to the plan member.
- A plan member must be actively at work on the effective date of a salary change.

It is very important that plan member information is kept up-to-date at all times, through the "update a member" functionality.

This ensures that your monthly premiums are totaled based on the most recent changes. It also helps us to process and pay claims accurately.

Recording plan member changes

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

- Salary changes (when coverage is based on earnings)
- Class/location change,
- Change in family status (e.g. from single to family),
- Adding dependents (newborns, change in spouse, etc.),
- Change in spousal coverage,
- Student information, and
- Termination of coverage.

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

Change from single to family status

When a plan member in the benefit plan with single coverage requests a change to family status, consider your plan type:

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

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

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

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

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

Notes:

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

Updating student information

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

To qualify as an over-age student, the learning institute that the dependent goes to must consider them a full-time student. We'll also consider co-op and apprenticeship programs. But, the over-age student must not be receiving Employment Insurance (EI) while they are in school.

An over-age student does not have to be living with the plan member to qualify as a dependent. And, they can be earning an income during their studies.

You must notify us if coverage for a dependent child is to continue past the lower age limit. This can be done through the Update a member page.

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

Once our system is updated to reflect that a dependent child is an over-age student, you'll need to inform us if this status changes in the future.

Coverage for an over-age dependent ends:

- On the first day of the next term if the student does not return to full-time studies
- On the date the student graduates

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

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

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

If your policy includes dependent life, we may ask for proof of enrolment if a death claim is received and will use this to validate whether a dependent is eligible for a claim payment. It is crucial that the member keep their dependent status up to date.

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

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

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

Adding coverage that was initially refused due to comparable coverage

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

Terminating coverage

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

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

Changes due to age or retirement

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

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

Changing a beneficiary designation

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

Plan members who are approved for disability

Sun Life will update the system to reflect the premium waiver for the appropriate benefits when:

- A member is receiving Long-Term Disability benefits or
- When a Waiver of Life Premium has been approved.

Statutory leave

You need to continue all coverage while a member is on statutory leave. You need to arrange to collect any premiums required from the members. However, if there are optional benefits that can be elected separately under the plan (e.g. Optional Life), the member may elect to cancel the optional benefits during the leave period.

Continuing coverage during a leave

- You do not need to notify us if all coverage is continuing for the province's legislated statutory leave period.
- You must let us know when a plan member's optional benefits is ending. We'll treat the cancellation of the optional benefit as a refusal. But, if your plan member re-elects the benefit, a **Health Statement** will be required.
- For plans where members contribute to premiums and do not want to pay their portion of the premium during the leave, members cannot choose to continue some benefits and cancel others. All benefits must be terminated.

Note:

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

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

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

If a plan member dies

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

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

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

Adding or changing Optional Life benefits

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

- The member must complete the optional benefits section of the Enrolment form. A Health Statement must also be completed. (See Submitting a Health Statement).
- The plan member must nominate a beneficiary, if choosing optional benefits for the first time.

Administrative reports

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

Administrative reports

- **Coverage Summaries** provide a member's:
    - current address,
    - benefit details,
    - dependent details, and
    - beneficiary information

  and will indicate if a Health Statement requires completion for full coverage amounts to be covered. A copy of the Coverage Summary is sent to the member any time a change of information occurs.

- **Member Change** Forms are pre-filled with member information on the left hand side. The member can complete the right hand side with new or changed information.

- **Member Coverage** Listing lists all your members' current coverage information, split by location. These reports also provide total number of lives and volume*, by benefit. (*Volume means the member's amount of coverage as outlined in the benefit details section of the Benefit Booklet. If the premium rate is expressed as a percentage of payroll then the volume is the member's eligible payroll amount, not the amount of coverage.)

- **List of Employees with Pending Benefits** lists all plan members that have pending benefits. You should review this report regularly and remind your members to submit a Health Statement. To access the form, select **Guides & forms** from the **Guides & Information** menu.

- **Overage Dependent Listing** lists all the dependents that are over the age limit for your plan. If you have received confirmation that these dependents are students, you need to update their dependent status on the **Update a member** page. If the overage dependent is not a student, terminate their record on the **Update a member** page.

Purchasing individual insurance when benefits end or reduce

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

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

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

If the Critical Illness coverage ends, the plan member and/or their spouse may continue with their coverage under a group Critical Illness plan that is offered by Sun Life Assurance Company of Canada at that time, without having to provide proof of good health. The written request must be submitted to us within 60 days from the date the coverage ends. The portability provision is subject to certain conditions that are outlined in the contract.

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

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

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

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

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

Special Requests

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

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

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

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

Administrative exceptions that require special handling

- **Waiver of waiting period** requests should be completed through the Special Request feature. We will consider the request to waive the waiting period and notify you of our decision.
- **Coverage for temporary work stoppages** such as layoffs, strikes, statutory leave, leave of absence and sabbatical. Approval is required if the covered period exceeds the greater of one month or the time limit outlined in the group benefits contract, or, for statutory leaves, the longer of the province's legislated statutory leave period or the limit outlined in the contract.
- **Coverage during a strike or lockout.**
- **Coverage for permanent work stoppages** such as permanent layoff and severance beyond the terms of the contract.
- **Request for out-of-country coverage extension.** Approval is required to cover a member or dependent who will be traveling or residing outside the country for business, pleasure or attending school beyond the time limits outlined in the group benefits contract.

When are employer-paid premiums taxable benefits?

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

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

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

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

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

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

Premiums

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

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

Pre-Authorized Debit (PAD)

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

How premiums are calculated

Premiums are calculated for complete months only.

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

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

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

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

Guides & information

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

What's new

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

Your administration guide

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

Guides & Forms

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

Contract & documents

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

Plan setup

Get details about your plan design at your fingertips.

Provincial health plans

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

Submitting claims

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

Internet and electronic

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

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

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

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

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

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

Paper – Mail

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

Members can download a personalized claim form from **mysunlife.ca**.

We assess claims based on the information you or your plan members send to us. So, it's important that you help us keep our records up-to-date. It's also important that you ensure all claim forms are fully completed, and that we receive them within the time limits specified in your contract.

Coordinating benefits with other plans

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

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

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

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

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

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

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

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

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

To claim the balance that was unpaid from the first plan, the member needs to send us the original claim statement received from that plan along with copies of the receipts or the initial Dental Claim Form. Receipts should include:

- the name of the patient,
- the nature of the treatment or medical product,
- the name of the prescribing doctor,
- the date and the amount charged.

Note:

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

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

You can access cards within the View a member page.

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

Extended Health Care

Extended Health Care benefits cover necessary medical expenses that are not covered by provincial hospital and medical plans. (For details, see your Benefit booklet available within the Contract & documents page.) For all medical expenses other than drug expenses payable under a drug card program, plan members must submit a completed Extended Health Care Claim through methods outlined above.

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

Note: Members should check their claim statement to ensure they actually received the services that were claimed. If the plan member is claiming expenses for a spouse or child, see the Coordinating benefits with other plans section.

Out-of-province medical expenses

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

- contact AZGA Service Canada Inc. (Allianz Global Assistance), our travel assistance service provider, immediately and
- follow the instructions in their Travel Benefit pamphlet (available at **mysunlife.ca**) To claim non-emergency, out-of-province medical expenses, members must complete an Extended Health Care Claim through methods outlined above.

Pay-Direct Drug plans

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

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

A drug card is available for the member within the

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

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

When the drug card does not work at the pharmacy

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

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

If the plan member receives less than the amount they expected

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

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

Maximum drug supply covered at one time

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

Items that cannot be purchased with the card

There may be some drug expenses covered under your plan that your plan members can't purchase with their drug card. See your Benefit booklet available within the Contract & documents page for a list of these items. The member will need to pay the pharmacy for these expenses and submit an Extended Health Care Claim.

Note:

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

Dependent records must be up to date

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

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

Lost or stolen cards

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

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

When a plan member leaves your company

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

Where to call

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

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

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

Dental Care

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

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

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

- deductibles
- co-insurance levels
- fee guides and maximums – as outlined in your Benefit booklet available within Contract & documents page.

Notes:

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

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

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

Plan members' eligible expenses must not be greater than the fee stated in the appropriate dental association fee schedule.

To submit a claim for Dental Care benefits:

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

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

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

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

Getting an estimate

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

Orthodontic claims

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

Health Spending Account

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

Personal Spending Account

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

Disability

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

Note:

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

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

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

Each part can be submitted separately once completed. But, the plan member statement and the attending physician statement should be sent directly to our group disability claims office. Claim forms must be received within the time limits indicated in your benefit booklet, available within the Contract & documents page.

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

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

Life

We've provided the following data for your information only. It is not meant to provide you with legal advice. Plan administrators must be careful not to provide opinions on the settlement of life insurance claims. Instead, we recommend that plan administrators direct all questions about a specific claim 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 they submit death claim. This is intended to help the family deal with immediate financial issues such as outstanding debts.

As a plan sponsor, the decision to offer a partial (advance) payment is at your discretion. We will not issue advance payments if there are any unusual events surrounding the member's death.

We need the following information to issue partial advance payments:

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

Note:

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

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

- Notification of Death form (see below),
- Proof of death in the form of a Physician's statement. Or an original or certified copy of a provincial death certificate. Or a funeral director's statement of death.
- Election of method of settlement and statement of claim form (see below), and
- The original Enrolment form and any subsequent Beneficiary Nomination forms.

For an Optional Life insurance claim, in addition to the above, we require:

- The original approval notice issued by us confirming approval of the member's application for Optional Life insurance, and
- A completed Physician's Statement:
  - if death occurs within two years of coverage being approved
  - or if the benefit is more than $250,000 and coverage has been in effect for less than five years.

  This is in addition to an official death certificate.

Notification of Death form

Following the death of a member or dependent, you will need to complete the appropriate section(s) of the Notification of Death form. Be sure to indicate:

- the correct plan member ID number
- group contract number,
- billing group number and class.

Then, you must sign and date this form to verify coverage. We should also be provided with all beneficiary forms.

Election of Method of Settlement and Statement of Claim form

If there is more than one beneficiary, send a complete Election of Method of Settlement and Statement of Claim form for each beneficiary.

Estate claims

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

For life insurance amounts we require

Less than $50,000	No additional documentation
More than $50,000, but less than $100,000	Notarized copy of the will Note: If the deceased plan member was a Québec resident who designated their estate as beneficiary. And if the proceeds exceed $50,000, we require a notarized copy of the notarial will.

Exceeding $100,000 and the deceased plan member was a resident of

Ontario	Notarized copy of the Certificate of Appointment of Estate Trustee with a will
Québec	Notarized copy of the notarial will
Any other province	Notarized copy of the probated will

Note:

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

If there isn't a will

For life insurance amounts we require

Ontario	Notarized copy of the Certificate of Appointment of Estate Trustee without a will
Québec	Notarized copy of the Notarial Declaration of Heirs
Any other province	Notarized copy of Letters of Administration

More about wills

To apply the terms of a will to the group Life benefit, the will must be dated later than the Enrolment form (if the Enrolment form designates a different beneficiary than is shown in the will).

If the beneficiary is the estate

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

If the beneficiary is a minor

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

How proceeds are paid

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

Criminal offence

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

Beneficiary pre-deceases member

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

Note:

- If a member is within 5 years of a scheduled termination they are not eligible for the program.
- If the loan is approved you must continue to remit premiums on the full amount of coverage and not the reduced amount.
- Before requesting a Living Benefits loan, you should contact your Sun Life group benefits representative to discuss the possible financial implications to your contract.
- Copies of the employee's enrolment form(s) should be submitted on all Waiver of Life Premium claims regardless as to whether Long-Term Disability is with Sun Life or not.

Simultaneous death

If the beneficiary and the member die at the same time (e.g. in the same accident), we try to determine the exact time of death, to determine who died first. If we can't confirm who died first, the Insurance Act and Québec Civil Code need 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:

- Fifty per cent of the lowest reduced amount of the Basic Life insurance.

We deduct the amount of the Living Benefits loan plus interest from the proceeds paid to the beneficiary(s) on the member's death.

Other claims

Waiver of Life Premium

This provides ongoing Life coverage for a disabled plan member (and/or covered dependents) without payment of premium during the disability period. It's subject to the terms of the contract that were in effect on the date the member became disabled. And it includes reductions and terminations.

Where Sun Life provides the Life benefit but not the Long-Term Disability benefit, we need the following:

- Employer's statement
- Waiver of premium claim – Claimant's statement
- Waiver of premium claim – Attending physician's statement of disability. This is needed to assess the Waiver of Life Premium claim.

Accidental Death & Dismemberment (AD&D)

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

Critical Illness Insurance

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

Administration and claim forms

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

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

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

Step 2 Select "Forms"

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

Contact information

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

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

SunAdvantage Client Services can be reached at:

Hours of operation:
8:30 AM – 4:30 PM ET Eastern, Ottawa, and Central Regions
10:30 AM – 7:30 PM ET Western Region

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

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

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

Web site address: smallbusiness.sunlife.ca

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