Sun Life Financial's Group Benefits

SunAdvantage
Administration Guide

Sun Life Financial

First Edition: November 2000

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Introduction

Introduction

Welcome to Sun Life Assurance Company of Canada, a member of the Sun Life Financial group of companies!

This guide includes the information you will need in the day-to-day administration of your plan. It's organized into easy-to-use steps and includes information on almost every aspect of plan administration and making claims, as well as answers to frequently asked questions.

Your company may not have coverage for all of the benefits described in this guide. You should consult your Sun Life Assurance Company of Canada group contract* for a description of your benefits.

** Whenever we refer you to the group contract, it means the group contract itself and the member benefit booklets. You should also refer to the group master card as it summarizes the benefit details of your group plan.*

Your Role

Your Role as Plan Administrator

As a plan administrator, you have an important role to play. You must gather all member information and pass it on to us electronically or manually, so claims can be paid quickly and accurately.

Please send us all initial member information and subsequent changes on a timely basis to allow us to bill the proper amount of premiums each month.

All forms used for plan administration include instructions but, if more information is needed, do not hesitate to call us. We will be pleased to help you.

If you need forms or supplies, complete the *Request for Supplies,* and fax or mail it to us.

If you need assistance, we're just a phone call away. Your contacts at the Company are listed on the ***Contacts List*** *given to you with this guide.*

Enroling

Enroling Members

How do you enrol a member?

- Ask the member to complete the enrolment form.
- Review the enrolment form and make sure it is fully completed and signed by the member. The beneficiary designation must be signed and dated in ink by the member as this is a legal document. The member must initial any changes, no matter how small. Correction fluid cannot be accepted.
- Give the member a copy of the member benefit booklet or any other documentation describing the member's coverage.

Beneficiaries For more information on beneficiaries, please read the *Beneficiaries* section of this guide on *page 7*.

Refusals For more information on refusals, please read the *Refusals* section of this guide on *page 5*.

Refer to your contract for specific requirements, such as

- when a member becomes eligible,
- when coverage begins, or
- when proof of good health is required.

Note: If your contract contains health, accident or disability benefits and covers Québec residents, your plan must comply with the requirements of the Québec Drug Insurance Plan. This means that the drug portion of the Extended Health Care benefit must at least match the basic drug plan provided by the Québec government, and that **members' participation in the plan be a condition of employment,** for both member and dependent coverage.

Are social insurance numbers used as identification?

If social insurance numbers are used as identification, you must have the member's written consent.

You can use the standard Company authorization form, or incorporate the following wording in to one of your forms:

"I authorize the use of my social insurance number for tax reporting, identification and the administration of my benefits."

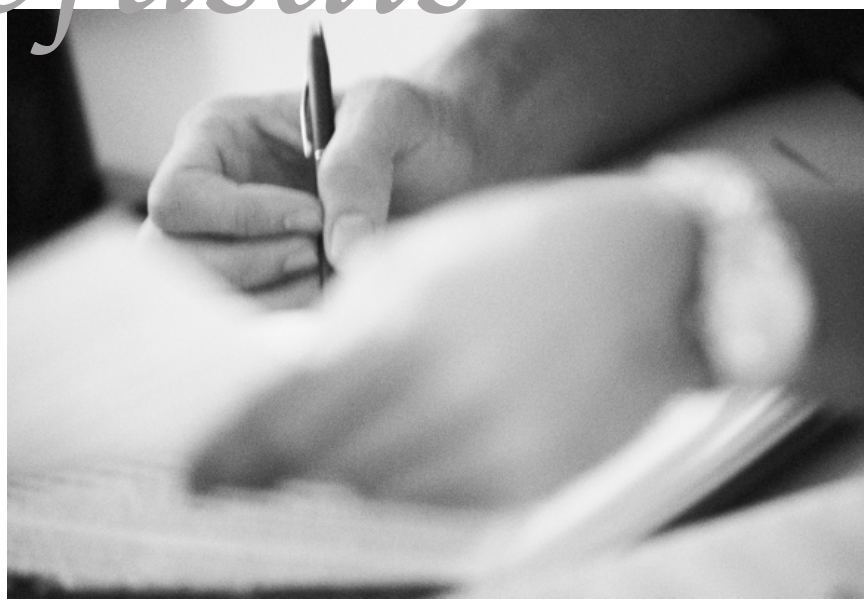
What is a late applicant?

If participation in the plan is not a condition of employment and the member submits an application for coverage more than 31 days after becoming eligible, the member is considered a late applicant and satisfactory proof of good health is required for the member and any dependents. In addition, reduced maximums may apply to the Dental Care coverage.

What do you do when a former member is re-employed?

If your contract contains re-employment conditions, the waiting period does not apply to a member who is re-employed within the number of months indicated in the contract. Coverage will be reinstated from the date of re-employment. If the re-employment is outside the number of months specified in your contract, the waiting period set out in the contract will apply.

Refusals



Refusals

All refusals of benefits by members must be documented in writing for future reference. This represents proof that coverage was offered to the member and declined.

For which benefits can a member covered under the spouse's plan refuse coverage?

A member who is covered for Extended Health Care and Dental Care benefits under a spouse's plan can refuse some of the benefits under the Sun Life Assurance Company of Canada group plan at any time. Make sure the member completes the appropriate section on the enrolment form that is applicable to the benefits he/she is applying for. Refusals of any benefits should be documented in writing.

What happens if the member loses coverage under the spouse's plan?

A member whose coverage terminates under the spouse's plan can apply for coverage under the Sun Life Assurance Company of Canada plan. If the member does not apply during the 31 days following the date coverage terminated under the spouse's plan, and if

- participation in the plan is **a condition of employment:** coverage will be provided retroactively under the Sun Life Assurance Company of Canada plan, on a premium paying basis to the date on which coverage terminated under the spouse's plan;
- participation in the plan is **not a condition of employment:** proof of good health will be required for the member and the dependents, and coverage will take effect on the date proof of good health is approved by us. In addition, reduced maximums may apply to the Dental Care coverage.

Can a member completely opt out of the plan?

If participation in the plan is **not a condition of employment,** a member can completely opt out of the plan. **Make sure the member completes a refusal form.**

Note: If your contract contains health, accident or disability benefits and covers Québec residents, your plan must comply with the requirements of the Québec Drug Insurance Plan. This means that the drug portion of the Extended Health Care benefit must at least match the basic drug plan provided by the Québec government, and that the **members' participation in the plan be a condition of employment,** for both the member and dependent coverage.

What happens if the member later wants coverage?

If a member refused coverage under the Sun Life Assurance Company of Canada plan and now wants coverage, the member is considered a late applicant and satisfactory proof of good health is required for the member and any dependents. In addition, reduced maximums may apply to the Dental Care coverage.

Beneficiaries

Beneficiaries

How to designate a beneficiary

If your Sun Life Assurance Company of Canada group contract includes Life benefits, the member should nominate a beneficiary at the time of enrolment, stating the **full name and relationship of the beneficiary to the member.** The Life Insurance benefits will be paid to this beneficiary in the event of the death of the member. The initial designation of a beneficiary is made on the member enrolment form.

The beneficiary designation 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 designation, no matter how small. Correction fluid cannot be accepted.

Acceptable Wording

Please refer to the *Beneficiary designation wording* on *page 9* of this guide for acceptable wording.

What if the member does not designate a beneficiary?

If no beneficiary is nominated, the benefits will be paid to the member's estate. If no beneficiary is nominated under the Spousal Optional Life benefit (if applicable), the benefits will automatically be paid to the member, if living, otherwise, to the member's estate.

What is a revocable beneficiary?

A revocable beneficiary means that the life insured (member) is free to change the beneficiary designation at any time. A beneficiary is assumed to be revocable in all provinces except in Québec.

What is an irrevocable beneficiary?

An irrevocable beneficiary means that the beneficiary has a vested interest in the Life Insurance and 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 designated as the beneficiary is presumed to be irrevocable unless specified as revocable. If the revocable box on the enrolment form or beneficiary change form is not checked off, the designation is irrevocable.

  Beneficiaries in Québec – For more information on beneficiary designations in Québec, please read the *Beneficiaries in Québec* section on *page 10* of this guide.

- **Irrevocable at the member's request –** If a member wishes to voluntarily designate a beneficiary as irrevocable, all that is required is for the member to write the word "irrevocable" on the beneficiary designation itself; for example, "John Doe, Spouse, Irrevocable".
- **Irrevocable by court ruling –** A beneficiary designation could be made irrevocable pursuant to 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.

How can a member make a beneficiary change?

If the beneficiary designation is revocable

A beneficiary change form must be completed, dated and signed by the member.

If the beneficiary designation is irrevocable

In order for a member to change the beneficiary designation from irrevocable to revocable, the member must submit one of the following documents:

- Assignment by Beneficiary to the Life Insured form, signed by the beneficiary, authorizing that the beneficiary designation can be changed to reflect the assignment.
- Final Decree of Divorce, if the irrevocable beneficiary is the spouse of the member (Québec only).
- Proof of death of the irrevocable beneficiary.

Beneficiaries in Québec – For more information on beneficiary designations in Québec, please read the *Beneficiaries in Québec* section on *page 10* of this guide.

Beneficiary designation wording

Below are some suggested designations and acceptable wording to be used on the member enrolment form or beneficiary change form.

Beneficiary designation	Acceptable wording of designation
Estate or Legal Heirs	Estate or Legal Heirs
One beneficiary	Martha Doe, wife
Two beneficiaries in succession (primary and secondary beneficiary)	Martha Doe, wife, or in the event of her death, Richard Doe, son
Two beneficiaries in equal shares	Jane and Mary Doe, children
Primary beneficiary followed by two secondary beneficiaries in equal shares	Martha Doe, wife, or in the event of her death, Jane and Mary Doe, children
Two beneficiaries in percentages (not in equal shares) Note: if one of the beneficiaries pre-deceases the member, the share of the deceased beneficiary would be paid to the member's estate. If that share should be paid to the remaining beneficiary, the following must be added:	John Smith 40% and Sally Smith 60%, parents *In the event of the death of one beneficiary, his/her share is to be paid to the surviving beneficiary.*
Trustee for minor children other than in the province of Québec	Mary and John Doe, children. Any payment becoming due during their minority to be made to John Smith, as Trustee or failing such Trustee, to the duly appointed guardian of such child as Trustee. Payment to said Trustee shall discharge the Company.
Trustee for minor children in Québec	Unacceptable by law

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.

Beneficiary designated in current group insurance plan	Possible beneficiary change
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 without revocability stipulation or 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 spouse's rights; or divorce 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	Any beneficiary
Husband designated on or after 1/7/70 but before 20/10/76 with irrevocability stipulation	Cannot be changed unless a waiver was signed; Divorce granted on or after 20/10/76 and before 1/12/82 terminating the husband's rights; or divorce granted on or after 1/12/82
Husband designated before 1/7/70	Any beneficiary
Wife designated before 20/10/76, and divorce granted before 20/10/76	Any beneficiary
Wife designated before 20/10/76, but divorce granted on or after 20/10/76 but before 1/12/82	Child until 20/10/77; otherwise wife's designation is irrevocable except if she waived her right or if divorce terminated her rights
Wife designated before 20/10/76, but divorce granted on or after 1/12/82	Any beneficiary, provided that he or she was designated after the divorce
Child designated on or after 20/10/77	Any beneficiary
Child designated on or after 20/10/76 but before 20/10/77	Child designation irrevocable if replaces wife or child designation made before 20/10/76. Otherwise any beneficiary

Child designated before 20/10/76	Wife until 20/10/77. Other child until 20/10/77. Otherwise irrevocable, unless a waiver is signed*
Any irrevocable beneficiary (beneficiary designated as irrevocable on the enrolment form) other than the wife	Cannot be changed, unless a waiver is signed*
Other beneficiary	Any beneficiary

**** Forfeiture of beneficiary rights is valid only if the signing beneficiary is of legal age.***

Updating

Updating Member Information

It is very important that 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.

Note that the **effective date** is required for any changes affecting a member's coverage – salary change, class change, addition and termination of member coverage or dependent coverage, and any changes impacting premiums or claims.

Below are some situations where you must update the member information.

What about salary changes?

When coverage is based on earnings, all salary changes must be processed as these have a direct impact on the premium calculation.

What happens when there is a change in marital status or in dependents?

A member can add or remove dependents after a birth, adoption, marriage, divorce or death. If the member **does not report the change** during the 31 days following the change, and

- participation in the plan is **a condition of employment:** coverage will be retroactive, on a premium paying basis, to the date of the change;
- participation in the plan is **not a condition of employment:** satisfactory proof of good health is required for the dependents, and coverage will take effect on the date proof of good health is approved by us. In addition, reduced maximums may apply to the Dental Care coverage.

Once dependent coverage is added for a member, any subsequent dependents will be covered automatically, unless you have positive enrolment.

If you have positive enrolment on your plan, meaning **all** dependent information is loaded in our claims system, the dependent section of the enrolment form must be completed in its entirety. If a claim is submitted for a dependent for which we do not have the information in our claims system, the claim will be rejected.

When does a member's coverage terminate?

Termination dates vary from one benefit to another. Usually, coverage terminates at the earlier of a certain age or retirement, or whenever employment ends. Your contract clearly indicates termination dates for each benefit.

Note that some coverage may continue under certain circumstances. Depending on your plan, some benefits can continue after a certain age or retirement. Dependent coverage may also continue after the member's death for a certain number of months, with or without the payment of premiums. *Refer to your contract for specific conditions.*

When Life coverage ends or reduces, the member and spouse can convert, without proof of good health, the cancelled Group Life coverage to Individual Life insurance. Complete the Notice of Conversion form and give it to the member immediately **as the written request for conversion must be submitted to the Company within 31 days from the date of loss of all or partial coverage.** The member must refer to the back of the form for the address and telephone number of the nearest Sun Life Assurance Company of Canada office, where their conversion request can be processed.

Are there other changes that affect a member's coverage?

There are other changes that affect a member's coverage. For instance, when a member's name changes, you must reflect the change in all records containing the member's name.

Approving

Approving Health Questionnaires

When insurance is approved following completion of a health questionnaire, an investigation may be conducted if the insured person dies within two years of the approval date.

Late applicant – A health questionnaire must be completed and submitted to the Company.

Excess coverage – Excess coverage means insurance coverage greater than the basic coverage or specific level indicated in your contract, and requires proof of good health beyond a specific level. That level is indicated in your contract. If a member is being enroled, or the amount of insurance is being increased for excess coverage, then a health questionnaire must be completed, and submitted to us. Until we approve the health questionnaire, the member will only be insured for the amount up to the excess coverage level indicated in your contract.

Until you receive written confirmation from Sun Life Assurance Company of Canada that the member's application has been approved by us for the full amount of insurance requested, payroll deductions must be made based on the amount of insurance up to the excess coverage level only.

You and the member will be advised of the date of approval for the excess coverage requested, and at that time payroll deductions should be adjusted to reflect the increased amount of coverage. Should the application be declined, you and the member will be advised, and coverage will remain at the existing coverage level.

How will we notify a member of the decision?

For all applications underwritten by the Company

- **If application is approved:** A letter will be sent to the member advising of our decision. The enrolment portion of the form as well as a copy of the letter will be returned to you. Both the enrolment portion and approval letter should be retained. In the event of a claim, both documents should be submitted to the Company.
- **If application is declined:** A letter will be sent to the member "private and confidential" stating the reason for decline. The enrolment portion of the application form will be returned to you with a letter advising of our decision. Both the enrolment portion and the letter should be retained.
- **If additional information is required:** A letter will be sent to the member "private and confidential" requesting the required information. A letter will also be sent to you advising that additional medical information is required.

Premiums

Premiums

Where do you send premium payments?

The address is indicated on the *Contacts List.*

What impacts monthly premiums?

The following situations affect the monthly premiums:

- enrolment or termination of a member
- addition or termination of dependent coverage
- salary or class changes
- approval or termination of waiver of premium for a member
- absence from work due to a lay-off or a leave of absence (including maternity leave).

How are premiums calculated?

For member enrolments or changes, including terminations:

Premiums are payable in advance and are calculated for complete months only or, in other words, **premiums are not calculated for part of a month.**

The following rules apply

- premiums are not payable for the first month during which coverage takes effect except when coverage takes effect on the first of the month, in which case the premium is payable for that month.
- premiums are payable for the last month during which coverage terminates except when coverage terminates on the first of the month, in which case the premium is **not** payable for that month.

However, the actual effective date of coverage or termination date is always used for claims purposes.

Examples

The following examples will help you understand how premiums are calculated

Example 1 – A member is enroled on January 1
*- premiums are payable **as of January 1***

Example 2 – A member is enroled on January 2
*- premiums are payable **as of February 1***

Example 3 – A member is terminated on January 1
*- the last month for which premiums are payable is **December***

Example 4 – A member is terminated on January 2
*- the last month for which premiums are payable is **January***

For contract changes

For any contract changes that do not begin on a premium due date, a **proportionate premium charge or refund** will, when applicable, be made from the date of the change.

What if you forget to report a contract change?

Premiums are calculated as indicated in the previous examples, and are charged retroactively to the effective date of the change.

Refunds are calculated as indicated in the previous examples retroactively to the later of

- the effective date of the change, and
- the last contract anniversary.

What happens if a member is on disability?

Premiums may be waived for certain benefits while the member is on disability and receiving disability benefits from the Company or from a government plan. Refer to your contract for specific requirements.

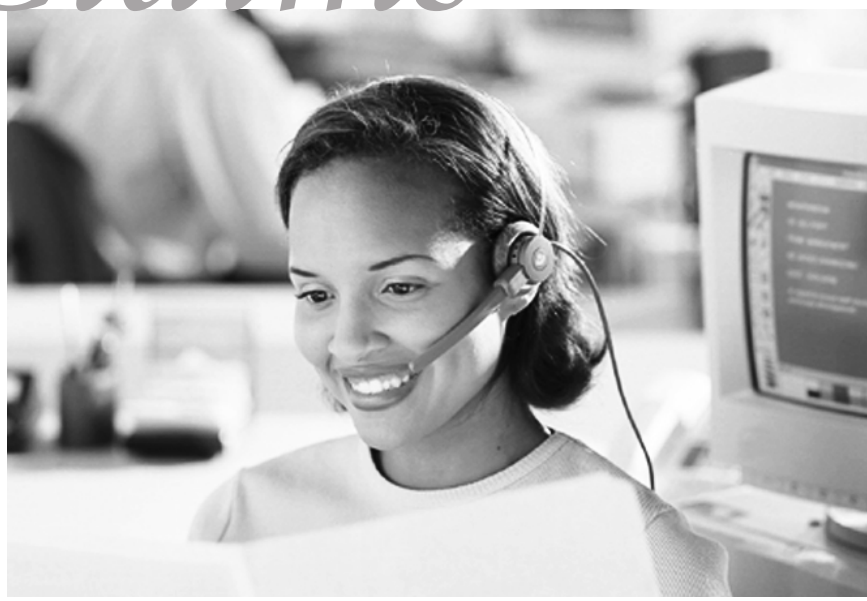
Are premiums payable during a leave of absence?

If coverage is continued during a leave of absence, premiums must be paid. Refer to your contract for specific requirements.

Are any taxes payable?

Any applicable provincial sales tax must be calculated and remitted with your premium payments.

Claims



Making Claims

Claims are reviewed based on the information that you and your members send to us. To ensure that claims are paid promptly, all claim forms must be fully completed and the member must make sure that any receipts are attached before submitting claims.

Please note that if a person is covered by more than one Extended Health Care or Dental plan, the person can co-ordinate benefits between the plans. You can help the member to determine which insurance company should receive the Extended Health Care or Dental Care claim first based on the guidelines included on the claim form.

Extended Health Care

All expenses other than drug expenses payable with a drug card under Assure Health Direct Payment or Deferred Payment plans

Extended Health Care coverage provides your members and their eligible dependents with financial assistance for necessary medical expenses which are not covered by provincial hospital and medical plans. Claims for hospital expenses are normally submitted directly to us by the hospital. Claims for other expenses should be submitted directly to us by the member. For information on what is covered under this benefit, refer to your contract.

- Ask the member to complete the claim form for Extended Health Care. If the member wants to make a claim for an expense incurred while travelling out-of-province, the member must phone Worldwide Assistance Services Inc. immediately and follow the instructions in the Medi-Passport brochure.
- The member should then attach all of the original receipts to the claim form, and keep a copy of the form and the receipts.
- The member should send the form to us (the addresses are listed on the back of the claim form).

We must receive all claims within the time limits indicated in your contract.

Drug expenses payable with a drug card under Assure Health Direct Payment plans

How the card works – The drug card is used for prescription drugs only. The card is accepted at most drug stores across Canada, and pharmacists refer to it as the Assure Card. *Other claims, such as physiotherapy or semi-private hospital charges, are not covered under the drug card plan and must be submitted to us using the Extended Health Care and Health Spending Account Claim form.* The drug card cannot be used outside of Canada.

Checklist for problem free claims adjudication – For claims to be adjudicated accurately, member data, including all eligible dependent information, must be reported to us promptly and must contain accurate information regarding:

- Dates of birth – if the date of birth reported to us for the member or dependents is inaccurate, the drug claim will be rejected at the pharmacy. In addition, special handling is required for multiple births (i.e. twins, triplets, etc). Please contact us for the proper enrolment process for multiple births.
- Coverage (single or family)
- Spouse covered under another plan – important for coordinating prescription drug coverage for other family members
- Student coverage – dependents who reach the minimum student age requirements of the plan must be clearly identified as full-time students. The change to student status must be made on or after the date the student qualifies for student coverage as an over-age dependent. **Any changes made prior to the minimum student age requirement will not be accepted.** Once the dependent reaches the minimum student age requirement, please advise us through your normal member update method (i.e. tape or list update or by using Sun Life Assurance Company of Canada's Positive Enrolment form or simply send us a letter or fax) by clearly indicating the student's name and date of birth. Once the dependent is recorded as a student in our files, they will continue to be eligible for coverage until they reach the maximum student age. Should a student not return to school, please be sure to advise us to terminate their coverage.

It is important to immediately inform us of any changes/additions such as:

- additional dependents (newborns, change in spouse, etc.)
- a change in spousal coverage
- student information as mentioned above
- lost or stolen cards

Coordination of benefits (COB) with other family members – We use CLHIA guidelines.

- If the member's spouse has **NO** coverage elsewhere:
  - the member can use the drug card for all members of the family provided he/she has family coverage.
- If the member's spouse has **SINGLE** coverage elsewhere:
  - only the member and dependent children can use the card.
  - the member's spouse must send a claim to his/her insurer first, **then submit the difference still owed to the spouse to us using the Extended Health Care and Health Spending Account Claim form.**
- If the member's spouse has **FAMILY** coverage elsewhere:
  - the children are covered under both plans; however, the plan of the parent whose month and date of birth is earliest in the calendar year is the first payor.

For example:

If the spouse's birthday occurs first in the year, then the spouse's plan is first payor and...	... the children's claims must be sent to the spouse's insurer first. *Any difference owing should be sent to us using the Extended Health Care and Health Spending Account Claim form.*
If the member's birthday occurs first in the year, then the Company is the first payor and...	... the member and children can use the drug card. *Any difference owing should be sent to the spouse's insurer using the insurer's paper claim form, along with the Explanation of Benefits.* ... the spouse's claims must be sent to his/her insurer first. *Any difference owing can be sent to us using the Extended Health Care and Health Spending Account Claim form.*

Deferred Payment Plans

Deferred payment plans work with a card like Direct Payment plans, except that members pay the whole drug cost to the pharmacy. The pharmacist sends claim information to Assure Health electronically and lets the member know what the plan will pay at the time the member is incurring the expense. Assure Health will mail reimbursement cheques to members when the total of expenses reaches a certain amount and at certain intervals, depending on the terms of your contract.

It is your responsibility to keep us advised of the members' most **current addresses.**

Erroneous addresses will result in delays in claim reimbursement. Please advise your members of the importance of keeping you informed of any address changes.

A card will be produced the first time information is received for a member. **A card will not be issued** unless there is a **complete address** on file. New cards are not produced when an address is changed.

Ideally, the address information should be updated and sent to us electronically. Manual processing of the information is also possible but can cause some delays.

To change an address you may call us at the number listed on your *Contact Card,* but you should also update your electronic version if applicable, otherwise the old address will be reloaded in our system at the next update.

Paper claims and Deferred Payment

When the drug card is not used, members should use the **Sun Life Assurance Company of Canada Extended Health Care and Health Spending Account Claim form** and submit their claim to us.

Dental Care

Dental coverage provides your members and their eligible dependents with financial assistance for reasonable dental expenses. For information on what is covered under this benefit, refer to your contract.

- The member and the dentist need to complete different parts of the Dental claim form.
- If the dentist has not electronically submitted the form to us, the member should send the form to us (the addresses are listed on the back of the claim form).

We must receive all claims within the time limits indicated in your contract.

When a person requires dental work over the pre-determination level indicated in your contract, we recommend that the member submit a completed dental claim form to us. We will review the proposed dental work and advise the member what we will pay.

Disability Benefits

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

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

- the *Member Statement* which must be completed by the member
- the *Attending Physician Statement* which must be completed by the doctor supervising the member's treatment
- the *Employer Statement* which must be completed by you, the plan administrator

Each part can be submitted separately once completed.

We must receive proof of claim within the time limits indicated in your contract.

When a member returns to work, complete the **Return to Work form** and send it to us immediately. If you or the member receive a payment which includes benefits for any period during which the member was able to work, return the payment to us for adjustment.

If you believe that the member will qualify for Long-Term Disability benefits or for waiver of premiums under the Life and Accidental Death and Dismemberment benefits, complete the **Notice of Claim form.** We must receive the form within the time limit indicated in your contract, preferably six to eight weeks prior to the commencement of the Long-Term Disability payments. Upon receipt of the notice of claim, we will open a claim record, and send you a guide on how to complete the relevant claim forms in order to make a claim.

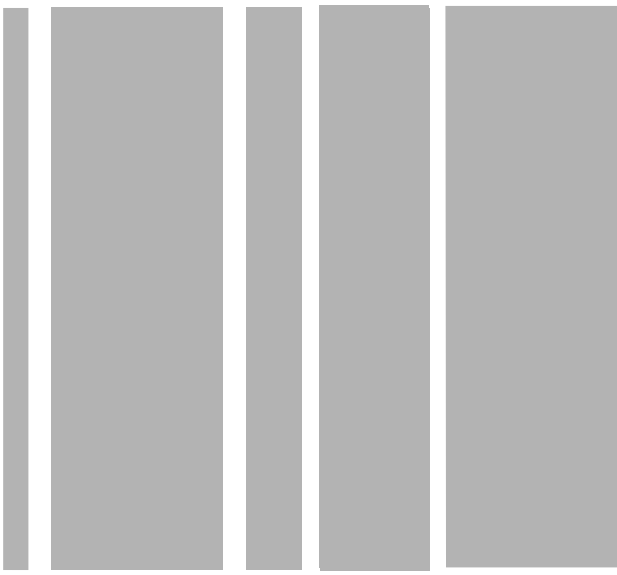
However, if a member is insured with us for both the Life and the Long-Term Disability benefits, the waiver of premium is automatically approved for the Life benefit once Long-Term Disability payments are approved. Notice of claim is not required for the Long-Term Disability benefit if the member is receiving Short-Term Disability benefits insured with the Company.

Please note that you must advise us if a member is receiving disability benefits under a government plan, as the member might be eligible for waiver of premiums.

Other claims

To make other types of claims (for example, when a member or dependent dies or a member becomes terminally ill, loses the use of a limb, sight, speech or hearing), call us and we will provide you with the information and the appropriate claim forms.

Under the Sun Life Assurance Company of Canada Living Benefit Loan Program, a terminally ill member with a life expectancy of 12 months or less may apply for a loan of up to 50% of the basic Life amount, to a maximum of $50,000, subject to any scheduled reduction. Before requesting a living benefits loan, a plan member should contact your group representative to discuss the possible financial implications to your contract.



Sun Life Assurance Company of Canada
Small Business Benefits
Group Client Services
PO Box 11010 Station A
Montreal QC H3C 4T9

Customer Service: 1 877 786-7227
Fax: (514) 399-1107
Fax Toll Free: 1 877 823-6605
E-mail: sbbcs@sunlife.com
Web site: www.smallbusiness.sunlife.ca

045-1695 (11.00) 100191