

GROUP ADMINISTRATOR GUIDE



WELCOME TO EQUITABLE LIFE OF CANADA®

Thank you for placing your Group Benefits business with **Equitable Life of Canada**. We value your business and will do our utmost to help you with the administration of your Group Benefits program.

We have provided this manual for you to use as a guideline when you have Administrative questions. If other questions should arise, do not hesitate to contact us for assistance.



TABLE OF CONTENTS

ABOUT EQUITABLE LIFE OF CANADA	5
OUR VISION.....	5
OUR MISSION.....	5
OUR VALUES	5
SOME IMPORTANT NOTES	6
HOW TO REACH US	7
SECTION 1: ADMINISTRATION OF YOUR GROUP PLAN	9
1. ENROLMENT OF NEW PLAN MEMBERS.....	9
2. DEPENDENTS ELIGIBLE FOR COVERAGE.....	10
Coverage for students over age 21:.....	10
Coverage for disabled dependent children:.....	10
3. SENDING THE ENROLMENT FORM TO EQUITABLE LIFE.....	11
4. GROUP BENEFIT CARDS	11
5. WHEN CAN A PLAN MEMBER OPT OUT OF BENEFITS?	11
Opting Out of the entire Plan:.....	11
Opting Out of the Health and/or Dental Benefit:.....	11
Coordination of Benefits for Health and/or Dental:	11
6. WHAT HAPPENS IF A NEW PLAN MEMBER GROUP INSURANCE APPLICATION IS SUBMITTED LATE?	12
7. WAIVING THE WAITING PERIOD	13
8. CHANGING A PLAN MEMBER'S BENEFITS/COVERAGE.....	13
Changing a Beneficiary	14
A Plan Member Marries (Legal Spouse)	14
A Plan Member Acquires a Partner	14
A Plan Member Wants to Change His/Her Name	15
Changing Health and/or Dental coverage	15
9. TERMINATING A PLAN MEMBER'S COVERAGE.....	15
When a Plan Members Employment Terminates	15
Conversion Privilege:	15
Leave of Absence, Lay-Off, Absence due to Sickness/Injury and Maternity/Parental Leave	16
Extension of Benefits/Severance Agreements	16
10. REINSTATING A TERMINATED PLAN MEMBER WHO RETURNS TO WORK.....	17
11. HOW TO REPORT PLAN MEMBER EARNINGS	17
12. EVIDENCE OF INSURABILITY.....	17
13. CALCULATING PLAN MEMBER PAYROLL DEDUCTIONS.....	18
14. CALCULATING A PRO-RATED PREMIUM	19
15. YOUR POLICY ANNIVERSARY (RENEWAL DATE)	19
16. SPECIAL INSTRUCTIONS FOR PAY DIRECT DRUG PLANS	20
a) Pay Direct Drug Plan with a card	20
b) Pay Direct Drug Plan without a card ("NO-CARD" Drug Plan)	22
17. ADMINISTRATIVE SERVICES ONLY (ASO) PLANS – AN OVERVIEW	23
SECTION 2: YOUR MONTHLY GROUP INSURANCE BILLING	24
1. READING YOUR MONTHLY GROUP INSURANCE BILLING	24
2. PAYING YOUR MONTHLY PREMIUM	24
3. A GUIDE TO YOUR GROUP INSURANCE BILLING.....	25

4.	GO GREEN WITH PAPERLESS BILLINGS	29
	SECTION 3: MANAGING CLAIMS	30
1.	PLAN MEMBER LIFE INSURANCE CLAIMS	30
2.	DEPENDENT LIFE INSURANCE CLAIMS.....	30
3.	PLAN MEMBER ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) CLAIMS	30
4.	QUICKASSESS	30
5.	PLAN MEMBER SHORT TERM DISABILITY (STD) CLAIMS	31
	The Plan Member Becomes Disabled	31
	The Plan Member Returns to Work	32
	The Plan Member Reaches the Maximum Benefit Period	32
6.	PLAN MEMBER LONG TERM DISABILITY (LTD) CLAIMS.....	32
7.	CLAIMS CONTROL (STD and LTD)	33
8.	EXTENDED HEALTH BENEFITS CLAIMS	33
9.	DENTAL CLAIMS	35
10.	DIRECT DEPOSIT FOR CLAIMS CHEQUES (ELECTRONIC FUNDS TRANSFER).....	35
11.	COORDINATION OF BENEFITS FOR HEALTH AND DENTAL	36
12.	SPECIAL CLAIMS SERVICES (COST PLUS).....	36
13.	SUMMARY OF HOW TO MAKE A CLAIM	37
14.	HELPFUL TIPS ON COMPLETING CLAIM FORMS	38
	Short Term Disability and Long Term Disability.....	38
	Health and Dental	38
15.	EZCLAIM	38
	EZClaim Mobile	38
	EZCLAIM Online	39

EQUITABLE LIFE OF CANADA

ABOUT EQUITABLE LIFE OF CANADA

Since 1920, customers have been depending on Equitable Life of Canada for financial protection. As one of the largest mutual life insurance companies in Canada, Equitable Life® is dedicated solely to its policyholders. Everything we do is focused on providing them with personalized service, security and wellbeing. Through Managing General Agencies and Advisors, Equitable Life offers a wide selection of competitive Individual Life and Health, Savings and Retirement and Group Benefits products to meet a range of financial planning and health needs. www.equitable.ca

OUR VISION

We are a **financially solid mutual company** and have achieved or exceeded the earnings, sales and expense management metrics from our strategic plan.

- We have an **engaged, motivated workforce** and are considered an employer of choice with a reputation for attracting, developing and keeping top talent.
- We are increasingly **recognized by advisors and customers** across Canada.
- We have secure, **agile technology** that meets the needs of customers and distribution partners, enables self-service and supports employee productivity.
- We are a visible and **socially responsible corporate citizen** committed to giving back to the communities in which we operate.

OUR MISSION

At Equitable Life, we are committed to **providing financial security** to our customers.

We will **grow** the Company by **delivering high quality services** and **competitive products**; building **stronger relationships with our distribution partners**; **engaging our people**; and positioning ourselves for **changing markets**.

We will achieve this through the following priorities:

- Increasing our market share by line of business
- Achieving lower unit costs
- Expanding distribution
- Making it easier to do business with us (e.g. Invest in technology)
- Developing products and services
- Developing a plan for changing markets
- Promoting a work environment of continuous improvement, innovation and excellence.

OUR VALUES

Our core values of . . .

- **Integrity**
- **Customer Focus**
- **Engaged Employees**

. . . will guide our decisions and the way we work with each other, our business partners and our customers.

SOME IMPORTANT NOTES

TERMS USED IN THIS GUIDE:

- "We", "us" and "our" refer to the Head Office of The Equitable Life Insurance Company of Canada (Equitable Life) located in Waterloo, Ontario, Canada.
- The term "Plan Member" also means "Employee".
- The term "Policyholder" also means "Employer".

THE BENEFITS AND PROVISIONS OF YOUR MASTER POLICY WILL PREVAIL:

The procedures outlined in this Group Administration Guide do not modify in any way the provisions of the Master Policy. The Master Policy issued by Equitable Life of Canada will govern all rights and obligations of a Plan Member insured under this Plan.

PRIVACY:

At Equitable Life, our commitment to protecting the confidentiality and security of our clients' personal information has and always will be the most integral part of our corporate values. Equitable Life® has adopted the ten privacy principles established by the Canadian Standards Association's *Model Code for the Protection of Personal Information*, which form part of the *Personal Information Protection and Electronic Documents Act*, establishing rules governing the collection, use and disclosure of personal information.

For more information concerning Equitable Life's privacy practices, please refer to our pamphlet entitled "*Our Commitment to Protecting Your Privacy*" (Form #7) which can be accessed on the Company website or obtained in hard copy through your Group Benefits Team at Equitable Life.

PLAN MEMBER BENEFIT PLAN BOOKLETS:

It is very important that all Plan Members are properly and fully informed of the details of their insurance coverage.

Plan Member Benefit Plan booklets are provided to you for distribution to each insured Plan Member. The booklet, together with the Plan Member Group Benefits Card, provides a description of the benefits for which each Plan Member is insured.

If you need more booklets:

Send an email request to groupbookletrequests@equitable.ca. Please be sure to indicate the Policy Number, Division and/or Class and the number you require.

HOW TO REACH US

One Westmount Road North
PO Box 1603 Stn Waterloo
Waterloo, Ontario N2J 4C7

Group Benefits Administration <i>Certificate Management, Billing Inquiries and Web Support</i>	Email: groupbenefitsadmin@equitable.ca Phone: 1 (800) 265-4556 x 283 Toll Free Fax: 1 (888) 878-7747
Hours of Operation: 8:15AM – 7:00PM EST 6:15AM – 5:00PM MST 5:15AM – 4:00PM PST	Email: groupcollection@equitable.ca Phone: 1 (800) 265-4556 x 640 Toll Free Fax: 1 (888) 878-7747
<i>Premium Payment and Collections Inquiries</i>	Email: groupcollection@equitable.ca Phone: 1 (800) 265-4556 x 640 Toll Free Fax: 1 (888) 878-7747
Third Party Administration/Self Administration Accounts	Email: grouptpasa@equitable.ca Phone: 1 (800) 265-4556 x 644 Toll Free Fax: 1 (888) 878-7747
Group Medical Underwriting <i>Paramedicals, Statements of Health, Attending Physician's Reports, Blood Profiles</i>	Email: groupmeduw@equitable.ca Phone: 1 (800) 265-4556 x 419 Toll Free Fax: 1 (888) 878-7747
Dental Claims <i>Dental Claim Inquiries</i>	Email: group-dental-claims@equitable.ca Phone: 1 (800) 265-4556 x 601 Toll Free Fax: 1 (888) 505-4373
Hours of Operation: 8:15AM – 7:00PM EST 6:15AM – 5:00PM MST 5:15AM – 4:00PM PST	
Health Claims <i>Health Claim Inquiries</i>	Email: group-health-claims@equitable.ca Phone: 1 (800) 265-4556 x 606 Toll Free Fax: 1 (888) 505-4373
Hours of Operation: 8:15AM – 7:00PM EST 6:15AM – 5:00PM MST 5:15AM – 4:00PM PST	
Group Disability Claims <i>Short Term (STD) and Long Term Disability (LTD) Claim Inquiries</i>	Email: group-disability-claims@equitable.ca Phone: 1 (800) 265-4556 x 1309 (STD)/x 1310 (LTD) Toll Free Fax: 1 (888) 505-4373
Hours of Operation: 8:15AM – 5:00PM EST 6:15AM – 3:00PM MST 5:15AM – 2:00PM PST	
Group Life Claims <i>Life and AD&D Claim Inquiries</i>	Email: group-life-claims@equitable.ca Phone: 1 (800) 265-4556 x 1311 Toll Free Fax: 1 (888) 505-4373
Hours of Operation: 8:15AM – 5:00PM EST 6:15AM – 3:00PM MST 5:15AM – 2:00PM PST	
Travel Assist 24 Hour Helpline <i>(Allianz Global Assistance I.D. #9089)</i>	Within Canada & U.S.A: 1-800-321-9998 Elsewhere Call Collect: 519-742-3287

- | | | |
|---|--------|------------------|
| <ul style="list-style-type: none">• Fraud Hotline
(Anonymous Call) | Phone: | 1 (800) 265-8899 |
|---|--------|------------------|

To receive the best possible service:

- Have your **Group Policy Number** handy;
- If your question concerns a particular Plan Member, please have the **Certificate Number** of the Plan Member in question available; and
- Ask for the appropriate Department (see next page).

You can advise us of certain changes, including Plan Member salary changes and terminations, and also submit claims by e-mail or Fax. E-mail addresses must contain the name of the Group Plan Administrator, as well as the company name, and should be marked "Private and Confidential".

Where to locate forms:

Many forms are available on our Website (www.equitable.ca). Follow the links to 'Group Benefits Forms' where you can download or print the required form.

SECTION 1: ADMINISTRATION OF YOUR GROUP PLAN

The Policyholder will designate the person(s) to administer the Policy (the "Plan Administrator"). The Policyholder is responsible for the Plan Administrator's actions in performing the administration and maintaining all records and documents used in performing this task.

The policy requires that Plan Members enroll for coverage, or for increases to coverage, within 31 days of becoming eligible. It is in the policyholder's best interest to ensure these deadlines are met. If the correct coverage is not in place within the required times, Plan Members could be inadequately insured and may have to submit Evidence of Insurability and could have coverage restricted if approved. In the event of a death or disability, the policyholder's liability could be substantial should a beneficiary or Plan Member initiate legal action as a result of being inadequately insured.

IMPORTANT: Provincial health coverage is required for all plan members in order to be eligible for Group Benefits under all policies with Equitable Life.

1. ENROLMENT OF NEW PLAN MEMBERS

New eligible Plan Members should complete all relevant sections on a **NEW PLAN MEMBER GROUP INSURANCE APPLICATION - FORM 191**. For legal reasons, it must be completed in ink, not pencil, and must contain the Plan Member's signature; otherwise the Application will be returned to you.

You, as the Group Plan Administrator, should complete Section A at the top of Form 191, indicating:

- The Group Policyholder name (your Company's name)
- The name of the Division/Subsidiary/Affiliate where the Plan Member works (if the person is employed at a Division/Subsidiary/Affiliate which is covered under your Group Policy)
- The Group Policy Number
- The Division Number
- The Plan Member's First, Middle and Last Names
- The Plan Member's Gender
- The Plan Member's Certificate number is assigned by your company
- The Plan Member's Occupation
- The Plan Member's Class (please refer to your Master Policy for the Class definitions)
- The Health Care Spending Account starting balance if applicable to your policy
- The exact date the Plan Member began working in a full-time, permanent position
- The Plan Member's exact earnings (see "How to Report Plan Member Earnings").
- The Plan Member's standard hours worked per week
- The Billing Sort Code (if the billing has been set up to be sorted and sub-totalled by location, department, etc.) up to 20 letters or numbers or a combination of letters and numbers

Before sending the Application to us, **check that all information is accurate and complete** to ensure the Plan Member receives the correct coverage:

- Be sure the data is **legible**;
- If the Plan Member is opting out of Health and/or Dental, ensure that the Forfeiture information on the application has been completed; and
- Ensure that a cheque marked Void or a stamped bank document is attached if Section F for direct deposit of claims has been completed

PLEASE REMEMBER TO KEEP A COPY OF FORM 191 FOR YOUR RECORDS

IMPORTANT: Is a Plan Member opting out of Health or Dental or does a Plan Member have a dependent but is not taking family coverage? Is a Plan Member refusing to join the plan? In Section 1, #5 "When can a Plan Member Opt Out of Benefits" gives further information on opting out of coverage.

If your Group Plan includes Plan Member Optional Life or Spousal Optional Life, any Plan Member who wishes to apply for this coverage should complete an **APPLICATION FOR PLAN MEMBER OPTIONAL AND SPOUSAL OPTIONAL LIFE BENEFIT - FORM 750** and a **STATEMENT OF HEALTH FOR GROUP INSURANCE - FORM 452**. Spouses wishing to apply for Spousal Optional Life should complete the same application forms. Eligible Plan Members can make application for the Group Optional Life benefit at any time while insured under the Group Policy.

2. DEPENDENTS ELIGIBLE FOR COVERAGE

Dependents eligible for coverage under the Group Plan must reside in Canada with Provincial health care coverage and include:

- The Plan Member's spouse. This means:
 - The legal husband or wife; or
 - The partner of the same or opposite sex who is living in a conjugal relationship with the Plan Member. Check the Master Policy (see the definition for "Spouse" in the Definitions section) to see if a Plan Member and a partner must live together for a specified period of time before the partner and the partner's children are eligible for coverage.
- The Plan Member's natural children, legally adopted children, stepchildren, and children of the spouse, provided those children normally live in Canada with the Plan Member or the Plan Member's spouse, do not themselves have a spouse or partner, and are not working on a full-time basis;
- The child, for whom the Plan Member is the legal guardian, provided the Policyholder agrees to such an addition and Equitable Life receives copies of the legal guardianship papers issued by the courts; and
- The child, for whom the Plan Member has lawful custody, provided the Policyholder agrees to such an addition and Equitable Life, receives copies of the legal custody papers issued by the courts.

Unless otherwise stated in the Master Policy, dependent children are covered up to age 21, or up to age 25 if a full-time student.

Coverage for students over age 21:

A child who is in full-time attendance at an accredited post-secondary educational institution (college or university) may continue to receive coverage if they are below the Maximum Age for Dependent Children specified in the Schedule of Benefits. They must continue to meet the definition of an eligible dependent according to the group policy. Some conditions include that the dependent has no spouse or partner, resides with the Plan Member or the Plan Member's spouse, and not be engaged in any work for pay on a full-time basis. Coverage for students attending school outside their home province will be modified or restricted.

Coverage will terminate at the earlier of withdrawal from classes or the end of the school term. However, coverage for continuing students will be without disruption during breaks between terms.

To maintain coverage for a continuing student, the Plan Member should complete an **APPLICATION FOR COVERAGE OF DEPENDENT CHILD OVER AGE 21 - FORM 441** when the child turns 21. To ensure uninterrupted coverage throughout their schooling year, please ensure the "Expected Completion Date of Schooling" field is completed.

Coverage for disabled dependent children:

Coverage may continue for an eligible dependent child who is developmentally or physically disabled, provided the child was insured under this Group Plan prior to age 21.

To apply to continue coverage for a disabled dependent child, in the 31-day period before the child's 21st birthday, the Plan Member should submit to us:

- An **APPLICATION FOR COVERAGE OF DEPENDENT CHILD OVER AGE 21 - FORM 441**; and
- A physician's statement indicating the nature of the medical condition and confirming that the child is incapable of self-sustaining employment and is dependent upon the Plan Member for support.

Please forward the form and physician statement to Equitable Life. These forms will be reviewed by our medical underwriting department and a copy of the approval/decline letter will be sent to your office when complete.

3. SENDING THE ENROLMENT FORM TO EQUITABLE LIFE

Please note: it is very important that we receive the application **FORM 191 NEW PLAN MEMBER GROUP INSURANCE APPLICATION** for new Plan Members within 31 days after the waiting period has expired, or the Plan Member may not have the expected effective date for the group coverage. Please refer to Section 1, #5 "What Happens if the Application Form 191 is Submitted Late."

4. GROUP BENEFIT CARDS

A Group Benefits Wallet Card is produced for every eligible Plan Member, and for every eligible adult dependent for that Plan Member (for example; spouse, overage student dependent). The card(s) will be sent to you outlining the Plan Member's effective date on the Group Plan and specifying if the coverage includes Semi-Private or Private Hospital, Health Benefits, Travel Assist and/or Dental Benefits. If your Group Plan has different waiting periods before certain benefits become effective, please be sure to advise the Plan Member when distributing the card. (For example, there might be a 3-month waiting period to join the Plan, but a 6-month waiting period before Dental becomes effective.)

5. WHEN CAN A PLAN MEMBER OPT OUT OF BENEFITS?

Opting Out of the entire Plan:

When your Group Policy became effective with Equitable Life, the Policyholder decided if coverage for Plan Members would be compulsory or voluntary. See the Participation Requirements on the face page of the Master Policy.

- If coverage is compulsory, then all eligible Plan Members must join; and
- If coverage is voluntary, a Plan Member can opt out of the entire plan, provided at least 85% of all eligible Plan Members are covered.

Please try to make Plan Members understand how valuable the insurance protection is and make every effort to convince them to join. If a Plan Member refuses, he/she must complete a **FORFEITURE OF GROUP BENEFITS - FORM 125**. Your signature is required on the form, to authorize us to allow a Plan Member to opt out of coverage. Send the original to us and keep a copy for your records. We will notify you of the decision in writing.

Opting Out of the Health and/or Dental Benefit:

Plan Members who join the plan must take all benefits for which they are eligible. Plan Members who have an eligible dependent (a spouse or child) should take family Health/Dental coverage. However, Plan Members who are covered for either of these benefits, with the exception of the Equitable HealthConnector™ Services through their spouse's plan may opt out of that benefit with Equitable Life. Or, Plan Members with dependents may want Health and/or Dental coverage for themselves only, if their dependents are insured elsewhere. Be sure the **Forfeiture Information** on Form 191 is fully completed.

Coordination of Benefits for Health and/or Dental:

It may be beneficial for Plan Members to have Health/Dental under both the Equitable Life Group Plan and under the spouse's Group Plan because they can then take advantage of the "**Coordination of Benefits**" provision in the Policy. The Plan Member and the spouse both submit their own claims to their own insurer. Claims for dependent children are first submitted to the insurer of the parent whose birthday (day/month) occurs earliest in the calendar year. Any unpaid balance is then submitted to the other insurer. The combined reimbursement from both insurers can equal (but not exceed) up to 100% of the amount of the claim.

Plan Members with dependents who wish to take advantage of this **Coordination of Benefits** should enrol for family Health and/or Dental when first joining the plan and complete the Coordination Information on Form 191.

Plan Members who have no dependents when they join the Plan and then later acquire an eligible dependent should provide this information on a **GROUP PLAN MEMBER CHANGE FORM - FORM 438**.

If both the Plan Member and spouse are employees of your company, they may wish to take advantage of Coordination of Benefits. Both should enrol for family coverage and coordinate their benefits to receive maximum coverage. If they do not want to co-ordinate benefits, one spouse then opts out of Health/Dental and the other takes family coverage (which

includes the spouse). The spouse who opts out of Health/Dental should still be covered under the Group Plan for the other benefits for which he/she is eligible (such as Life, Dependent Life, AD&D, and Disability).

Plan Members who decide not to use the Coordination of Benefits when they first join the Plan or when they first acquire an eligible dependent (and therefore opt out of Health and/or Dental) and later want to utilize this provision, must submit satisfactory **evidence of insurability**. **NOTE:** Dental coverage will be restricted to a maximum of \$250 per insured person for the first twelve months of coverage.

If a Plan Member does decide to opt out of Health and/or Dental:

A new Plan Member should complete the **Forfeiture Information** on the **NEW PLAN MEMBER GROUP INSURANCE APPLICATION FORM 191**.

A Plan Member who takes Health/Dental and later wants to opt out due to spousal coverage should complete the **Forfeiture Information** on a **GROUP PLAN MEMBER CHANGE FORM 438**.

Please be sure that the form indicates the name of the alternate carrier, the name of the spouse's insurer and that the form is signed and dated.

Plan Members can opt out of Health and/or Dental, with the exception of the Equitable HealthConnector™ Services if they have comparable coverage through their spouse's plan. If that alternate coverage through the spouse should terminate, the Plan Member can apply for family coverage with Equitable Life, without having to provide evidence of insurability, as long as we are notified within 31 days of the date the spouse's coverage terminates.

6. WHAT HAPPENS IF A NEW PLAN MEMBER GROUP INSURANCE APPLICATION IS SUBMITTED LATE?

The "Eligibility" section in your Master Policy indicates the waiting period (if any) that a Plan Member must serve before becoming eligible for coverage on the Group Plan.

If we receive the Plan Member's Application form before any waiting period has expired, the Plan Member's insurance coverage will be effective on his/her "date of eligibility" (the day following the end of any waiting period).

If we receive the Plan Members Application form after the date of eligibility but prior to 31 days, the employee will be effective on the date of eligibility.

If we receive the Plan Member's Application form more than 31 days after any waiting period has expired, the Plan Member is considered a "late applicant" and must submit satisfactory evidence of insurability. A **STATEMENT OF HEALTH FOR GROUP INSURANCE - FORM 452** should be sent to us with the **NEW PLAN MEMBER GROUP INSURANCE APPLICATION - FORM 191**. If the Plan Member is applying for coverage for eligible dependents, information on the dependents can be provided on the Statement of Health. Our Group Medical underwriting department will contact the Plan Member if further information is required. If coverage is approved, you, as the plan administrator, will be notified in writing. Note that coverage will not be backdated. Our Group Medical Underwriting department will also advise the Plan Member of the decision in writing.

IMPORTANT: A late applicant for the Dental Benefit will be allowed on the Group Plan on the following basis: During the first 12 months, all Dental coverage is limited to a maximum of \$250 for each insured person. Notification of this restriction will be included in the approval letter sent to you and the Plan Member. After a Plan Member is insured under the Group Plan for twelve consecutive months, full coverage will apply. It is very important that Plan Members apply for all coverage for which they are eligible when they first become eligible!

7. WAIVING THE WAITING PERIOD

From time to time, you may want to request that the waiting period be waived for a particular Plan Member. For example, a new executive may be hired on the condition that coverage begins as of his/her date of employment. We will treat these requests as an exception to the usual provisions of your Master Policy. Equitable Life of Canada must approve each case and we reserve the right to decline the request. We must receive requests within 31 days of the date of hire. To apply for this exception:

- Submit the **New Plan Member Group Insurance Application** - Form 191 as soon as the person is hired, along with a written request; or
- Submit **Request to Waive the Waiting Period** – Form 193, and the Plan Member's application. Please fully explain the reason for the request.

Once we receive the documentation, a decision will be made as to whether the waiting period can be waived or if further information is required. For example, we may require satisfactory evidence of insurability.

If approved, the entire waiting period will be waived; we would not waive a partial waiting period. For example, if your policy has a three-month waiting period, we would not add the Plan Member to your Plan after serving one or two months of the three-month waiting period.

8. CHANGING A PLAN MEMBER'S BENEFITS/COVERAGE

A Plan Member may become eligible for a change in benefits and/or coverage because:

- A change in occupation could mean a move into a different Class;
- A change in earnings could mean a change in benefit amounts; or
- A legal marriage, common-law marriage, separation, divorce or birth of a child could affect dependent coverage.

Any such changes in coverage need to be reported and made within 31 days of the event to avoid late applicant status. If any coverage is applied for more than 31 days after the applicant first becomes eligible, the person for whom coverage is being requested is a late applicant and will need to submit satisfactory Evidence of Insurability. (See #12, Evidence of Insurability.)

Changes in benefits or coverage are usually effective on the date the change occurred (unless the Policy states otherwise). However, the Plan Member must be actively at work full-time on that date for any increase to become effective. If not actively at work (for example, if the Plan Member is disabled), the increases will not be effective until the Plan Member returns to full-time work. If the increase affects dependent coverage, a dependent who is hospitalized on the date of the change will be eligible for the increase after final discharge from the hospital. Decreases in benefits/coverage are effective on the date of the change.

Your authorization is required on the **Group Plan Member Change Form** (438). The Plan Member should provide you with the completed form for your records and for you to provide your signature authorizing the change.

PLEASE REMEMBER TO KEEP A COPY OF FORM 438 FOR YOUR RECORDS

Change in Earnings or Occupation

To ensure all Plan Members' benefits are current and accurate, be sure to notify us as soon as they receive a change in earnings or occupation. It is important that we always have the most current earnings on file; otherwise:

- Plan Members who become disabled may not be paid the amount of Short Term Disability or Long Term Disability payments to which they are entitled; and/or
- Beneficiaries may not receive the full amount of Life Insurance proceeds to which they may be entitled.

To report changes in earnings or occupations, complete a **PLAN SPONSOR'S REPORT ON NEW PLAN MEMBERS, TERMINATIONS & CHANGES - FORM 200**. If your payroll system produces a list of earnings, you may submit this instead. The list you provide must indicate the Plan Members' names, Certificate numbers, new earnings and the effective date of the new earnings. Your signature must be present. You can advise us of certain changes (such as changes in earnings, occupation and terminations) by e-mail. Be sure to mark these "Private & Confidential". Please note that your e-mail address must include your name and your company's name. Send your email to groupbenefitsadmin@equitable.ca.

If a Plan Member's change in earnings results in their being eligible for an amount of insurance over the No-Evidence Limit, satisfactory Evidence of Insurability must be submitted in order for the excess amount to be considered. (See #12, Evidence of Insurability.)

Changing a Beneficiary

Plan Members may designate a beneficiary and a contingent beneficiary on the **NEW PLAN MEMBER GROUP INSURANCE APPLICATION FORM 191** when first joining the Group Plan. A Plan Member can change the beneficiary designation (subject to any laws governing beneficiaries) at any time by completing a **GROUP PLAN MEMBER CHANGE FORM 438**. The change in beneficiary will be effective on the date the Plan Member signs the form.

Plan Members can choose any number of beneficiaries. However, the percentage distribution should be indicated for each beneficiary, and must equal exactly one hundred percent. Examples:

- A person, such as a spouse, fiancé, child, brother, sister, mother, father, a friend, etc;
- An organization such as a charity or a church; and
- The Plan Member's "estate". If the Plan Member names the "estate" as beneficiary, the Group Life Insurance proceeds are paid to the estate and could be subject to the claims of any creditors. If a specific beneficiary is named, the insurance is paid to that beneficiary, and is protected from claims on the estate.

If any beneficiary is a minor child (under age 18), the Plan Member must name a trustee or payment of the insurance proceeds might be delayed in the courts.

Note: All beneficiary designations must be completed in ink. They must be legible and the relationship to the Plan Member must also be clearly indicated. If the beneficiary designation is ambiguous, payment of the Life Benefits could be disputed or delayed in the event of a Life Claim. Note: Plan Administrator authorization is not required for a beneficiary designation change.

A Plan Member Marries (Legal Spouse)

The Plan Member should complete Section 1 on the **GROUP PLAN MEMBER CHANGE FORM 438**. We should receive written notification of changes to Plan Members' status within 31 days of the date of marriage to avoid late applicant status for the spouse.

The Plan Member can indicate on Form 438 if there is to be any change in Health/Dental coverage (for example, to opt out of these benefits or to apply for the Coordination of Benefits). Also, please be sure to ask Plan Members if they wish to change their beneficiary designation. If so, they should complete a **GROUP PLAN MEMBER CHANGE FORM 438**.

A Plan Member Acquires a Partner

Please see the definition of "Spouse" in #2 "Dependents are Eligible for Coverage"

A partner is treated in the same way as a legal spouse and is eligible for the same benefits (although only one spouse can be covered at a time). Check the definition of "Spouse" in your Master Policy to see if the Plan Member and partner must live together for a specific period of time before the partner and the partner's children (if any) can be covered.

The Plan Member should complete the **GROUP PLAN MEMBER CHANGE FORM 438** within 31 days of the start of co-habitation to avoid late applicant status. If your Policy states that the Plan Member and partner must live together for a specified time before the partner and the partner's children (if any) can be covered, the form should be sent to Equitable Life within 31 days after that waiting period has expired.

On **Form 438**, the Plan Member can indicate if there is to be any change in Health/Dental coverage. If the Plan Member wants to change the beneficiary, a **GROUP PLAN MEMBER CHANGE FORM 438** should be completed.

A Plan Member Wants to Change His/Her Name

Plan Members who get married or divorced and want to change their last name, or Plan Members who change their name for any other reason, should complete the **GROUP PLAN MEMBER CHANGE FORM 438**. The Plan Member should indicate their new marital status, if applicable. Please be sure to ask Plan Members if they wish to change their beneficiary designation.

Changing Health and/or Dental coverage

Plan Members may choose to change their Health and /or Dental coverage for a variety of reasons:

- A single Plan Member may acquire a spouse or a dependent child and want to change to family coverage;
- A Plan Member who had opted out of Health/Dental may now need family coverage because the spouse's coverage has terminated; and
- A Plan Member with family coverage may now want single or no Health/Dental benefits due to a change in family status.

If a Plan Member wants to change their Health and/or Dental coverage, they should complete a **GROUP PLAN MEMBER CHANGE FORM 438** to update their coverage.

A Plan Member may want to apply for family coverage because the spouse's coverage has terminated. Application for change must be submitted within 31 days of the date the spouse's coverage terminated so the spouse and any dependent children being added to the plan will not be considered late applicants.

Any spousal changes (legal or common law) must also be reported with 31 days.

9. TERMINATING A PLAN MEMBER'S COVERAGE

When a Plan Members Employment Terminates

Use a **PLAN SPONSOR'S REPORT ON NEW PLAN MEMBERS, TERMINATIONS & CHANGES - FORM 200** to advise us of Plan Member terminations.

IMPORTANT: The Policy specifies that coverage terminates on the Plan Member's last day of active work. Coverage does not continue until the end of the month. Notify Equitable Life of terminations as soon as possible, to reduce the possibility of claims being paid after the Plan Member has terminated. We provide premium credit for terminated Plan Members to a maximum of 3 months. If there were any claims incurred after the Plan Member's termination date, a letter will be sent directly to the Plan Member requesting repayment of these claims.

Conversion Privilege:

A Plan Member who terminates employment can apply to convert up to \$200,000 of his/her Group Life Insurance of group insurance to an Individual Life Insurance policy issued by Equitable Life of Canada without having to submit evidence of insurability with the exception of plan members who reside in Quebec who can convert up to \$400,000.

The following coverage may also be eligible for conversion, provided the Group Plan includes the benefit, and the Individual policy meets any minimum amount requirement as determined by Equitable Life:

- The amount of Dependent Life Insurance on the Plan Member's spouse. (note: The amount of Dependent Life on dependent children is not eligible for conversion with the exception of Quebec residence who can convert as long as the amount is \$5,000 or more); Plan Member Optional Life; and
- Spousal Optional Life.

The Plan Member (or the Plan Member's spouse, in the case of Dependent Life and Spousal Optional Life) must apply for conversion and pay the first premium within 31 days of terminating from the Group Plan. The premiums for the Individual policy are based on the individual's age, gender, and whether or not the person is a smoker.

If a Plan Member is interested in applying for a conversion, contact your Group Benefits Administration Team. We will send the Plan Member a quotation and the appropriate forms.

Leave of Absence, Lay-Off, Absence due to Sickness/Injury and Maternity/Parental Leave

Leave of Absence:

All benefits can be continued for **up to 3 months** while a Plan Member is on a leave of absence (unless your Master Policy states otherwise and subject to the approval of Equitable Life). If benefits are continued, monthly premiums remain payable during that time. Please provide a written request to continue benefits for a Plan Member on leave. The request should be submitted at the start of the leave and it should include the Plan Member's expected "return to work" date.

Temporary Lay-Off:

All benefits can be continued for **up to 3 months** (unless your Master Policy states otherwise and subject to the approval of Equitable Life). If benefits are continued, monthly premiums remain payable during that time. It is up to the Policyholder to decide at the time of lay-off if coverage is to be continued for Plan Members or terminated until the lay-off period is over. Whatever your company decides, all laid-off Plan Members must be treated in the same manner.

If your company decides to continue coverage while the Plan Member is on a temporary lay-off, you must send a written request to Equitable Life at the start of the Plan Member's lay-off, giving the lay-off date and estimated "recall" or "return to work" date. If your plan includes the Short Term Disability Benefit and/or Long Term Disability Benefit, the benefit can remain in force during the lay-off. However, no disability benefits are payable during the temporary lay-off period. Provided the Plan Member is still totally disabled on the date the Plan Member was expected to return to work from the temporary lay-off, benefit payments commence on the later of the scheduled date of return to work or the date benefits would commence according to your disability plan.

Absence due to Sickness/Injury:

For Plan Members away from work because of disability due to sickness or injury, all benefits can be continued while the person is disabled (unless otherwise specified in your Master Policy and subject to the approval of Equitable Life). Coverage would, however, terminate according to the Termination Provisions in the Policy (such as when the Plan Member reaches the Maximum Age for Coverage). Monthly premiums remain payable (except for Life Insurance if the Plan Member has been accepted for Life Waiver, and except for Long Term Disability if the Plan Member is receiving benefit payments). If your company decides to continue coverage while the Plan Member is on a leave due to sickness or Injury, you must send a written request to Equitable Life at the start of the Plan Member's leave, giving the start date of the absence and estimated "return to work" date.

Maternity/Paternal Leave:

When a Plan Member is on maternity/parental leave, we strongly recommend that he/she keep all of their benefits in force. Please make sure that Plan Members understand that if they choose to forfeit coverage during this time, they will not be covered for any expenses or disabilities that occur during their leave. Plan Members should understand that there is the possibility that they could lose their coverage entirely if they become permanently disabled while on leave.

If a Plan Member does decide to forfeit all benefits while on maternity/parental leave, Equitable Life requires notification clearly indicating the Plan Member's intentions. The written notification should also include the start date of the leave, as well as the anticipated "return-to-work" date. When the Plan Member returns to work, we must be notified in writing within 31 days from the date they returned; otherwise the Plan Member will be treated as a "late applicant" and coverage can only be reinstated if satisfactory evidence of insurability is provided.

Important: Equitable Life recommends that you check your provincial employment laws to ensure that you are in compliance with respect to providing Group Insurance Benefits during a maternity/parental leave.

Extension of Benefits/Severance Agreements

Occasionally, your company may wish to extend benefits as part of a severance agreement for a Plan Member who has been permanently terminated. Without approval from Equitable Life, you can extend Health and Dental Benefits up to a maximum of 180 days, and all other benefits can be extended by the period required by legislation. Any extensions of benefits beyond these periods require the approval of Equitable Life. Please notify us in writing of all extensions and include the Plan Member's date of termination and the date to which benefits are to be continued. Be sure to specify which benefits are to be extended. For example, your company may want to extend the Basic Life, AD&D and Health and Dental benefits.

The following also applies:

- Disability benefits (Short Term Disability and Long Term Disability) can only be extended during an in lieu of notice period; and
- If the Group Life insurance is extended, at the end of the extension period, the Plan Member may decide to convert their Group Life insurance coverage to an Individual policy (up to a maximum of \$200,000), provided the Plan Member applies for Conversion **within 31 days** of the end date.

10. REINSTATING A TERMINATED PLAN MEMBER WHO RETURNS TO WORK

Unless otherwise stated in your policy, Plan Members who are re-hired within 12 months of terminating can be reinstated on your Group Plan as of the date they return to full-time work, as long as we receive notification within 31 days of their return. The Plan Member:

- Does not have to serve any waiting period again;
- Can be covered for amounts up to any no-evidence limits in your Policy unless previously declined by our Medical Underwriting Department; and
- Does not have to complete a new Application Form 191.

Please be sure all data we have on file (earnings, beneficiary designation, marital status, Health and/or Dental coverage) is still correct and, if your Health Benefit includes a Pay-Direct Drug Plan, check that the dependent (spouse/children) data has not changed since the Plan Member terminated.

A Plan Member who is re-hired more than 12 months after terminating is treated as a new Plan Member and must:

- Serve any waiting period before becoming eligible for coverage, and
- Complete a NEW PLAN MEMBER GROUP INSURANCE APPLICATION - FORM 191.

Send a **PLAN SPONSOR'S REPORT ON NEW PLAN MEMBERS, TERMINATIONS & CHANGES** - FORM 200 to us advising of the Plan Member's return to work date, and **NEW PLAN MEMBER GROUP INSURANCE APPLICATION FORM 191** (if applicable) within 31 days of the Plan Member's return to work date, to avoid late applicant status.

11. HOW TO REPORT PLAN MEMBER EARNINGS

If any of your Group Benefits are calculated on the basis of earnings, it is essential that Equitable Life have the correct and current earnings on file to ensure that each Plan Member has the amount of insurance for which they are entitled under the terms of your contract.

Section 1 'Definitions' in your Master Policy defines exactly how Plan Members' earnings should be reported. Unless otherwise stated in the Policy, "earnings" do not include such items as bonuses, overtime pay, gratuities, profit-sharing plans, dividends, and expense allowances. If any of these are included, your Policy explains how to calculate the amounts.

Please be sure to:

- Follow the earnings definition in your Policy when reporting earnings amounts on the Plan Member's NEW PLAN MEMBER GROUP INSURANCE APPLICATION - Form 191 or on the PLAN SPONSOR'S REPORT ON NEW PLAN MEMBERS, TERMINATIONS AND CHANGES - Form 200; and
- Notify us promptly when a Plan Member's earnings change to ensure that benefit amounts are adjusted appropriately (see Section 1, #7a "Change in Earnings or Occupation"). In most cases, benefit amounts change as of the date the earnings change.

It is very important that we always have the most current earnings on file. Otherwise, Plan Members who become disabled may not be paid the amount of Short Term Disability or Long Term Disability payments to which they believe they are entitled. Or beneficiaries may not receive the full amount of Life Insurance proceeds to which they may be entitled, according to the terms of your Master Policy contract.

12. EVIDENCE OF INSURABILITY

Evidence of Insurability is required for the following cases:

- Late applicants;
- Late dependent applicants;
- Late application for Coordination of Benefits;
- Amounts over the No Evidence Limit; and
- Application for optional benefits.

Provide the Statement of Health forms to the applicant to be underwritten: Statement of Health for Group Insurance - Form 452. The Plan Member should submit the completed form directly to Equitable Life, Group Medical Underwriting Department.

Equitable Life will notify you of decisions regarding acceptance or decline of coverage, or request additional information if necessary. The Plan Member will be contacted directly by our Group Medical Underwriting Department if further information is required, and will be notified of acceptance or decline of insurance.

Late applicants (those applying for coverage after 31 days of eligibility) must provide satisfactory Evidence of Insurability and be medically underwritten. Approved applicants are subject to a restriction of their dental coverage of \$250 per insured person for the first year of coverage, and may be subject to other restrictions of coverage.

Coverage for Plan members insured on your Group Policy may be subject to certain Non-Evidence Limits (NELs). Non-Evidence Limits are the benefit amount above which a Plan Member's benefit amount can be increased only after they provide satisfactory evidence of insurability.

Any coverage being applied for with Evidence of Insurability is not effective until approved by Equitable Life. Once coverage is approved, your billing will be updated accordingly.

If you have any questions about whether evidence of Insurability is required in a particular situation, or if evidence has previously been submitted, and you wish to confirm whether new Evidence is required, please contact the Group Benefits Administration department at Equitable Life.

13. CALCULATING PLAN MEMBER PAYROLL DEDUCTIONS

If your Plan Members pay part of their Group Insurance premiums, you will need to calculate the appropriate amount of payroll deductions. The **CURRENT TRANSACTIONS** section of your monthly billing statement shows the monthly cost of the coverage for each Plan Member. If you subtract the Policyholder contribution from that, the balance is the Plan Member's cost.

Example:

A Plan Member's monthly premium is \$240.00. The Policyholder pays 50% (= \$120.00). The Plan Member's share is also 50% (= \$120.00). You would then convert this to your payroll basis as follows:

- If payroll deductions are monthly, the Plan Member share is \$120.00;
- If payroll deductions are twice monthly, divide the Plan Member share by 2 (= \$60.00);
- If payroll deductions are every two weeks (bi-weekly), divide the Plan Member share by 2.17 (= \$55.30); and
- If payroll deductions are weekly, divide the Plan Member share by 4.33 (= \$27.71).

Payroll deductions for a new Plan Member should start on the first pay after the effective date of the person's coverage. The last deduction for a terminating Plan Member should be on the last pay the Plan Member receives.

14. CALCULATING A PRO-RATED PREMIUM

Individual premiums are pro-rated daily for any changes in coverage that occur during the billing period, such as additions and terminations of Plan Members and increases and decreases in coverage (there will be a charge or credit for partial months.)

Calculating Pro-Rated Premium:

Basic Life, Optional Life, AD&D and Disability

$(A \times B \times C) / D$ = Pro-rated premium amount

Where:

A = Volume amount (Life/1000), (AD&D/1000), (LTD/100), (STD/10)

B = Number of days pro-rata

C = Rate of Benefit

D = Number of days in the month

Dependent Life

Dependent Life is a flat rate and will display a "Y" if the certificate holder has Dependent Life. This benefit will apply to those certificates that include dependents.

$(B \times C) / D$ = Pro-rated premium amount

Where:

B = Number of days pro-rata

C = Rate of Benefit

D = Number of days in the month

Health and Dental – For Single and Family Coverage

$(B \times C) / D$ = Pro-rated premium amount

Where:

B = Number of days pro-rata

C = Rate of Benefit

D = Number of days in the month

15. YOUR POLICY ANNIVERSARY (RENEWAL DATE)

Each year, approximately four months before your Policy Anniversary (renewal) date, you will receive an **Earnings/Occupation Verification Worksheet** showing the Plan Members covered under your Group Plan, their Class, earnings and occupations. It is very important that you check this list carefully to be sure all eligible Plan Members are covered and that their earnings and occupations are current and correct. If a Plan Member should die or become disabled, claims would be paid up to the amount that had last been reported to us. If a Plan Member or beneficiary does not receive the amount of benefits they feel they are entitled to receive, there is the possibility that your Policyholder could face litigation. Please refer to Section 1, #11 "How to Report Plan Member Earnings" for more information.

Each year, approximately one month before your renewal date, your premium rates will be recalculated based on the number of Plan Members covered, their ages, gender, volumes of insurance and claims experience. The owner of your policy will be notified of any change in your rates. The new rates will take effect one month after your Policy Anniversary date. Your next monthly premium billing will include any changes in premium resulting from the rate change.

The **CURRENT TRANSACTIONS** section of your monthly billing statement reflects the most current data we have on record. For example, the amounts of each Plan Member's benefits (if based on earnings) are calculated using the last earnings data you submitted to us. Please check it against your payroll records to ensure that all eligible Plan Members are covered and for the appropriate amounts and benefits.

NOTE: Have you been considering changes to your Group Plan (such as adding a benefit or changing any deductibles, reimbursement percentages or maximums)? The best time to investigate plan changes is about two months prior to your Policy Anniversary. Please contact either your advisor or our Equitable Life Group Marketing Manager who will be happy to provide you with a quotation regarding benefits, available plans and costs.

16. SPECIAL INSTRUCTIONS FOR PAY DIRECT DRUG PLANS

There are two types of Pay-Direct Drug Plans. Both plans use electronic processing to verify drug coverage. If the drug is considered an eligible expense, the only cost that needs to be paid by the Plan Member (or dependent) is any deductible and the amount not reimbursed by the plan.

Pay Direct Drug Plan with a card: Plan Member is provided with a pay-direct drug card to use when purchasing prescription drugs at a pharmacy.

Pay Direct Drug Plan without a card: Plan Member is not provided with a pay-direct drug card. To benefit from their pay-direct drug plan, Plan Members must have their prescriptions filled by a specific mail-order pharmacy chosen by their policyholder.

a) Pay Direct Drug Plan with a card

After enrolling on the Group Plan, each Plan Member receives a Group Benefits Drug Card to use when purchasing prescription drugs at a pharmacy. One card is issued for Plan Members and additional cards are provided for each eligible dependent over the age of 21. Over-age dependent children (students) are issued their own card, which displays their own name.

The person submitting the prescription gives both the drug card and the prescription form to the Pharmacist who will then check the Pay Direct Provider's database. The pharmacist will verify the patient's information; that the Plan Member's coverage is still in force; that the drug plan the Policyholder has chosen covers the drug being prescribed and whether the plan covers only generic drugs. If the patient is registered with the Pay Direct provider and the drug is eligible, the only amount that needs to be paid by the Plan Member/dependent is the deductible amount (if any) and any amount not reimbursed by the plan.

If the drug is not eligible, or the patient information is not registered with the Pay Direct provider, the entire cost of the prescription must be paid by the Plan Member/dependent and the paper claim form **EMPLOYEE REIMBURSEMENT FORM FOR DRUG CLAIMS - FORM 466PD** should be submitted directly to the Pay Direct provider. The address is provided on the claim form.

Enrolling Plan Members and dependents on the Pay-Direct Drug Plan

When completing the **NEW PLAN MEMBER GROUP INSURANCE APPLICATION FORM 191**, Plan Members wishing to cover their spouse and/or dependent children must complete Section C, providing the details on the spouse and children. It is very important that names and dates of birth are provided accurately, as this information is used for claims adjudication. Equitable Life forwards this information to our Pay Direct provider so that the dependent(s) will be registered and eligible claims will be reimbursed. If a Plan Member has opted out of Health coverage with Equitable Life, be sure the Plan Member has completed the **Forfeiture of Group Health and/or Dental Benefits** Information on Form 191.

Eligible dependent children over age 21 who are attending school full-time are considered "**over-age dependents**" and must have their own drug card. See the following page for instructions on how to apply for coverage for Overage Dependents.

Each Plan Member on the Drug Plan should be given the pamphlet "**YOUR PAY-DIRECT DRUG PLAN - FORM 219**" which provides information on the drug plan. A supply will be sent to you with the drug cards.

Changes in a Plan Member's coverage under the Pay-Direct Drug Plan

To enroll any additional dependents, Plan Members must complete the **GROUP PLAN MEMBER CHANGE FORM 438**.

It is very important that all of the Plan Member's eligible dependents are registered with the Pay Direct Provider. Even a newborn baby should be registered promptly so any drug claims for the child can be paid without delay.

If a Plan Member's coverage is changing from family to single coverage due to a change in family status (such as divorce or separation), or if the Plan Member is now opting out of Health Benefits under the Group Plan, the Plan Member must notify us on a **GROUP PLAN MEMBER CHANGE FORM 438**.

Terminating a Plan Member or dependent from the Pay-Direct Drug Plan

When a Plan Member terminates or a dependent is no longer eligible for coverage, please notify Equitable Life immediately on a **PLAN SPONSOR'S REPORT ON NEW PLAN MEMBERS, TERMINATIONS & CHANGES FORM 200** so we can notify the Pay Direct provider. It is also very important to collect all of the Plan Member's drug cards, including any given to Overage dependents. You can destroy them at your office.

What happens when a dependent child reaches age 21?

Please refer to your Master Policy or Plan Member Benefit Booklet, Group Benefits for the maximum age for coverage for dependent children. If your Plan covers dependent children over age 21 who are in school full-time, these children must have their own drug card which shows the dependent's own name. To apply, the Plan Member should complete the **APPLICATION FOR COVERAGE OF DEPENDENT CHILD OVER AGE 21 - FORM 441**. Alternatively, the Plan Member can provide a copy of the tuition fee receipt or timetable, or a letter from the Office of the Registrar confirming the dependent's full-time student status.

Coverage will terminate at the earlier of withdrawal from classes or the end of the school term. However, coverage for continuing students will be without disruption during breaks between terms. To maintain coverage for a continuing student, the plan member should complete an **APPLICATION FOR COVERAGE OF DEPENDENT CHILD OVER AGE 21 – FORM 441** when the dependent child turns 21. To ensure uninterrupted coverage throughout their schooling, please ensure the "Expected Completion Date of Schooling" field is completed.

What if a Plan Member loses his/her drug card?

Please contact Equitable Life's Group Benefits Administration department to order replacement drug cards. Equitable Life will issue additional cards to reflect certain changes, such as name and coverage changes etc. These cards reference the original "Issue Number". We encourage Plan Members to present new cards to the Pharmacist to ensure that files are maintained accurately.

Why might a drug card not be accepted at a Pharmacy?

Plan Members may not be able to use their drug card for the following reasons:

- The date of birth for the spouse or child was incorrectly provided on the Form 191 (it is very important that Equitable Life has the correct date of birth for the plan member and each dependent-the patient's date of birth submitted to the Pay Direct provider by the pharmacist must match the date of birth on file);
- The person did not present the drug card to the pharmacy;
- The person did not present the new drug card in the case of an issue number change due to a lost or stolen card;
- The pharmacy is not part of the Pay Direct network;
- Form 191 was not submitted so the Plan Member or dependent is not yet enrolled in the plan;
- Coverage for the Plan Member or dependent has terminated;
- The prescription is for an over-age dependent who has not applied for his/her own drug card, or has not submitted Form 441 to confirm they are in school full time still;
- Coordination of benefits needs to be applied, and the spouse's or dependent child's claims need to be submitted to the other insurance carrier first. (See section 4 B, "Coordination of Benefits" in this section.); or
- A keying error has been made by the Pharmacy.
-

In these situations, the person requesting the prescription will have to pay the full cost at the pharmacy and then submit an **EMPLOYEE REIMBURSEMENT FORM FOR PAY DIRECT DRUG CARD CLAIMS - FORM 466PD** to the Pay Direct provider for reimbursement of the eligible amount.

Pharmacies have access to the Pay Direct provider pharmacy Call Centre via a toll-free support line. In many cases, the Call Centre is able to assist the pharmacist and immediately resolve problems relating to the drug card acceptance so that claims can be processed.

Occasionally, the pharmacist may key in the information from the card incorrectly and the prescription the Plan Member or Dependent is trying to have paid will be rejected. If the information from the card is not keyed in properly, the prescription will not be covered, (assuming the prescription is eligible under the group benefit plan). Here is a guide to the numbers appearing on the Group Benefits Card:

- The first 2 numbers on the card indicate the carrier number (29) for Equitable Life of Canada;
- The next set of 6 numbers is the Policy number of the group plan;
- The next 10 numbers is the Plan Member's Certificate Number;
- The next 2 numbers are the 'issue number', and begin at 01 (the Issue number will change if the original card is lost or stolen); and
- The last 2 numbers are the 'relationship code' of the card holder.

When would a Plan Member have to pay "out-of-pocket"?

When purchasing drugs at a pharmacy, a Plan Member (or dependent) will usually only pay the deductible or any coinsurance as specified in his/her plan. However, in the following situations they will have to pay the full cost of the drug:

- If the Pharmacist does not accept Pay Direct provider Inc. drug cards;
- If the drug plan has a deductible per prescription, the person must pay that amount;
- The drug purchased is not eligible under the drug plan that the policyholder has chosen;
- If the reimbursement on the drug plan is less than 100%, the person must pay the difference; or
- The pharmacist is charging more than the average cost for the drug, in which case the Pay Direct provider will only reimburse the average cost, and the Pharmacist may choose to charge the person for the difference.

b) Pay Direct Drug Plan without a card ("NO-CARD" Drug Plan)

A "no-card" drug plan is one that combines the "pay-direct" aspect and the "reimbursement" aspect of an Equitable Life Drug Plan.

The Pay Direct provider processes the claim if the prescription is filled by the specific mail-order pharmacy that was chosen by the policyholder (such as MediTrust Pharmacy Inc.). If the drug is eligible, the only cost to the Plan Member/dependent is the deductible amount (if any) and any amount not reimbursed by the plan. This is the "pay-direct" portion of the plan.

The "no-card" plan is designed to encourage Plan Members and their dependents to use the mail-order pharmacy because the dispensing fee per prescription may be lower than many pharmacies charge. As well, for eligible drugs, the person placing the order does not have to pay the entire cost of the prescription (other than any deductible or reimbursement balance).

If the prescription is filled at a regular pharmacy, or if the Plan Member/dependent uses a mail-order pharmacy other than the one specified by the policyholder, they will need to pay the full cost of the drug, and then submit an **EXTENDED HEALTH CARE CLAIM FORM 466** to Equitable Life for reimbursement. This is the "reimbursement" portion of the plan.

The policyholder chooses the specific Pay Direct drug plan. If the plan includes fertility drugs or smoking cessation products, these are not covered under the "pay-direct" portion. While the person can order these through the mail-order pharmacy, the claim for such drugs is submitted to Equitable Life under the "reimbursement" portion of the plan. Similarly, if the Plan Member/dependent has not been registered with Pay Direct provider, the prescription can be filled through the mail-order pharmacy but the claim must then be submitted to Equitable Life for payment (provided the dependent is not a late applicant).

Enrolling, changing and terminating Plan Members and dependents on a "no-card" drug plan

For a "no-card" drug plan, new Plan Members provide their spouse/dependents data on the **NEW PLAN MEMBER GROUP INSURANCE APPLICATION - FORM 191**. Equitable Life forwards this information to the Pay Direct provider to register the Plan Member and dependents. If a Plan Member is opting out of Health due to coverage on their spouse's plan, be sure the Plan Member has completed Section B on Form 191. Please remind the Plan Member of the importance of utilizing "coordination of benefits" (Section 1, #4 "When Can a Plan Member Opt Out of Benefits").

Information on new dependents being added should be sent to us on a **GROUP PLAN MEMBER CHANGE FORM 438**.

17. ADMINISTRATIVE SERVICES ONLY (ASO) PLANS – AN OVERVIEW

ASO is the acronym for Administrative Services Only, which is a method of self-insurance. ASO Plans are available to groups who meet certain requirements. Your Equitable Life Group Marketing Manager and /or advisor can provide more information on ASO arrangements. Policyholders might chose to have certain benefits (Health and Dental and sometimes Short Term Disability) on an ASO basis, to gain favorable tax status, control over claims exceptions, and freedom over plan design and plan management flexibility.

Please note that certain administrative practices should be followed for ASO plans. If your Group policy with Equitable Life terminates, you should be aware that claims payment ceases effective the date of termination. Claims received at Equitable Life's Head Office on or before the termination date will be processed and paid as appropriate under the policy. Any claims not received at Equitable Life by that date are not eligible for payment, regardless of the date incurred; claims received after that date will be returned. If your plan is moving to a new group plan provider, those claims should be submitted to the new carrier.

SECTION 2: YOUR MONTHLY GROUP INSURANCE BILLING

1. READING YOUR MONTHLY GROUP INSURANCE BILLING

Your monthly premium billing contains three parts (see Section 2, #3 A Guide to Your Group Insurance Billing):

- The PREMIUM STATEMENT shows the billing due date and the total premium payable, as well as the name and telephone extension number of your Group Benefits Administration Team at Equitable Life;
- The ADJUSTMENT TRANSACTIONS page shows changes in coverage (such as Plan Members being added or terminated, and increases or decreases in coverage) and the adjustments in premiums resulting from those changes; and
- The CURRENT TRANSACTIONS section lists all the Plan Members covered under the Group Plan, their current coverage and total premium.

The **DUE DATE** on the Invoice is the date on which the premium is payable. You have 31 days from this date to remit premium.

2. PAYING YOUR MONTHLY PREMIUM

Please make your cheque payable to **Equitable Life**. Please be sure to indicate your Policy Number on the front of your cheque and return the top copy of our Invoice with your payment

Premium cheques must be received at our Head Office within 31 days of the Billing Due Date. We want to stress how important it is that premium payments are made on time. If payment is not received within 31 days of the due date, the Group Insurance coverage for your Plan Members will lapse or terminate. If this should happen, a Plan Member could sue your Policyholder for loss of protection if a claim was incurred but declined because the Policy had lapsed. Your liability could be substantial, especially in the event of a Death or Long-Term Disability claim.

We should receive your premium within 31 days of the due date. At the 35 day mark past due, a First Late Payment Notice will be sent to you. If we still have not received payment by the 45th day past due, we will send a Second Late Payment Notice, and Health and Dental Claims will be placed in suspense. Once we receive your payment in full, we will lift the claims suspension and claims reimbursement will resume.

PLEASE PAY THE EXACT AMOUNT BILLED! Please do not make adjustments for Plan Members who have terminated or been added, etc. If the exact amount is not paid, this makes accounting procedures very difficult. Depending on the amount we receive, a partial payment may not be applied to your account until the full balance is received. If your current billing does not reflect the change in coverage for a Plan Member, the adjustment will be reflected on your next month's billing. If you do not see the change reflected on the next billing, please contact Equitable Life's Group Benefits Team, so that we can confirm that we did receive the change.

Note: If you would like to pay your premiums by our **Pre-Authorized Debit (PAD) Plan**, please contact our Group Collections Team at Equitable Life for details.

Payments for ASO (Administrative Services Only) benefits

a) Monthly Billing Payments

Please remit one cheque for the Insured and ASO amount. The payment is allocated to the applicable benefit as per the billed amount. If we do not receive enough funds to cover the entire amount billed, premium will first be allocated towards the insured benefits. After funds have been allocated to the insured benefits, any additional funds will be allocated toward the ASO benefits.

b) Additional Payments (Quarterly Reconciliation Payments)

In addition to your monthly bill payments, we receive payments to satisfy the balance due on the quarterly reconciliation. These payments are deposited and credited separately from the monthly bill payments. Customers are requested to mark these cheques as ASO and return a copy of the reconciliation for backup, to ensure that the funds are correctly allocated to the ASO account.

3. A GUIDE TO YOUR GROUP INSURANCE BILLING



Equitable Life of Canada®

One Westmount Road North, PO BOX 1603, Stn. Waterloo, Waterloo, ON N2J 4C7

C/O First Last, Group Plan Administrator
The Company
123 Street
Town, Province
A1A 1A1

8

GUIDE KEY

1. Billing Related Contact Information
2. Notice of Premium Statement (billing); two copies of front page are forwarded, one for the client's file, the second for remittance with payment to Equitable Life
3. Date for which Premium is due
4. Policy number pertaining to this billing
5. Division number pertaining to this billing
6. Summary of account including current amount owing, arrears and deposits made to Equitable Life
7. Total amount owing
8. Client name and address
9. Remittance reminder

Statement For November 1, 2010 - November 30, 2010

2

Please Return This Copy With Your Premium

Due Date: 01 Nov 2010

3

Policy Number: 111111

4

Division: 001

5

Current Prem/Fee Owing
Past Amounts Due
Total Owing
Less Deposits
Please Pay This Amount

6

\$15,000.00

\$15,000.00

\$1,200.00

\$13,800.00

7

1

For Billing Inquiries: 1 800 265-4556 Ext. 283

groupbenefitsadmin@equitable.ca

9

Please pay as billed. Payments and changes in coverage after the date prepared will appear on the next statement. Please ensure that your policy number is clearly marked on your cheque and all other correspondence submitted to us.

Reference Number: 123456

Prepared by Equitable Life of Canada on October 16, 2010

GST/HST # 10521 0470



Equitable Life of Canada®

One Westmount Road North, PO BOX 1603, Stn. Waterloo, Waterloo, ON N2J 4C7

C/O First Last, Group Plan Administrator
The Company
123 Street
Town, Province
A1A 1A1

1. Notice of Premium Statement (billing); two copies of front page are forwarded, one for the client's file, the second for remittance with payment to Equitable Life

Statement For November 1, 2010 - November 30, 2010

Please Keep This Copy For Your Records

1

Due Date: 01 Nov 2010

Policy Number: 111111

Division: 001

Current Prem/Fee Owing	\$15,000.00
Past Amounts Due	
Total Owing	\$15,000.00
Less Deposits	\$1,200.00
Please Pay This Amount	\$13,800.00

For Billing Inquiries: 1 800 265-4556 Ext. 283

groupbenefitsadmin@equitable.ca

Please pay as billed. Payments and changes in coverage after the date prepared will appear on the next statement. Please ensure that your policy number is clearly marked on your cheque and all other correspondence submitted to us.

Reference Number: 123456

Prepared by Equitable Life of Canada on October 16, 2010

GST/HST # 10521 0470

Adjustment Transactions

111111 Div. 001 The Company

Name	Certificate	Class	Benefit/Service	Volume	Rate	Prem/Fee	Tax	Total
1 Last, First 01 Jun 2010 TO 30 Jun 2010	2 0000000160	B	3 Basic Life AD&D LTD	5 100,000 100,000 2,600	6 0.084 0.033 1.373	8.40 3.30 35.70	0.57 0.26 2.86	9.07 3.56 38.56
Total							47.40	51.19
Last, First 01 Jul 2010 TO 31 Jul 2010	0000000160	B	Basic Life AD&D LTD	100,000 100,000 2,600	0.084 0.033 1.373	8.40 3.30 35.70	0.57 0.26 2.86	9.07 3.56 38.56
Total							47.40	51.19
Last, First 01 Aug 2010 TO 31 Aug 2010	0000000160	B	Basic Life AD&D LTD	100,000 100,000 2,600	0.084 0.033 1.373	8.40 3.30 35.70	0.57 0.26 2.86	9.07 3.56 38.56
Total							47.40	51.19

Adjustment Totals	Benefit/Service	# of Certs	Prem/Fee	Tax	Total
8	Basic Life	1	42.00	3.35	45.35
	AD&D	1	16.50	1.30	17.80
	LTD	1	178.50	14.30	192.80
	Total		237.00	18.95	255.95
01 Nov 2010 Premium Adjustments (Premium Correction) -			793.07	0.00	793.07
9					
Div. 000 Adjustment Totals	Benefit/Service	# of Certs	Prem/Fee	Tax	Total
10	Misc Adjustments		793.07	0.00	793.07
	Total		793.07	0.00	793.07

GUIDE KEY

1. Insured's name
2. Insured's Certificate ID
3. Insured's class
4. Billing Period (From:To)
5. Itemization by benefit
6. Example: the first column is the Volume (or coverage type); the second column is the Rate; the third column is the Premium/Fee for this item; and the fourth is the Tax
7. The total payable for this itemized line
8. Summary of the divisions adjustments by benefit
9. Miscellaneous Adjustments
10. Final Summary of the divisions Adjustments by benefit

Current Transactions

111111 Div. 001 The Company

Name	Certificate	Class	Benefit/Service	Volume	Rate	Prem/Fee	Tax	Total
1 Last, First 01 Nov 2010 TO 30 Nov 2010	2 0000000160	3 B	Basic Life	100,000	0.084	8.40	0.67	9.07
			AD&D	100,000	0.033	3.30	0.26	3.56
			LTD	2,600	1.373	35.70	2.86	38.56
			Total			47.40	3.79	51.19
Last, First 01 Nov 2010 TO 31 Nov 2010	0000000160	B	Basic Life	100,000	0.084	8.40	0.67	9.07
			AD&D	100,000	0.033	3.30	0.26	3.56
			LTD	2,600	1.373	35.70	2.86	38.56
			Total			47.40	3.79	51.19
Last, First 01 Nov 2010 TO 31 Nov 2010	0000000160	B	Basic Life	100,000	0.084	8.40	0.67	9.07
			AD&D	100,000	0.033	3.30	0.26	3.56
			LTD	2,600	1.373	35.70	2.86	38.56
			Total			47.40	3.79	51.19

Current Totals	Benefits/Services	Total Volume	# of Certs	Prem/Fee	Tax	Total
	Basic Life	300,000	1	42.00	3.35	45.35
	AD&D	300,000	1	16.50	1.30	17.80
	LTD	7,800	1	178.50	14.30	192.80
	Total			237.00	18.95	255.95

Div. 001 Current Total	Benefits/Services	Total Volume	# of Certs	Prem/Fee	Tax	Total
	Basic Life	300,000	1	42.00	3.35	45.35
	AD&D	300,000	1	16.50	1.30	17.80
	LTD	7,800	1	178.50	14.30	192.80
	Total			237.00	18.95	255.95

Bill Totals (Current + Adjustments)	Benefit/Service	Prem/Fee	Tax	Total
	Basic Life	42.00	3.35	45.35
	AD&D	16.50	1.30	17.80
	LTD	178.50	14.30	192.80
	Total	237.00	18.95	255.95

10

Tax Includes:

ON PST \$13,737.55

ON HST \$818.88

Services provided by:

Ceridian Canada's Employee Assistance Program (EAP)

Second Opinion from WorldCare™ Inc.

FeelingBetterNow® from Mensante Corporation

The Cancer Navigation System™ from CAREpath™ Inc.

11

GUIDE KEY

1. Insured's name
2. Insured's Certificate ID
3. Insured's class
4. Billing Period (From:To)
5. Itemization by benefit
6. Example: the first column is the Volume (or coverage type); the second column is the Rate; the third column is the Premium/Fee for this item; and the fourth is the Tax
7. The total payable for this itemized line
8. Summary of the divisions totals (by column/benefit)
9. Summary of Bill Totals (Current plus Adjustments)
10. Breakdown of Tax by province charged on this bill
11. Summary of HealthConnector Service Providers

Reference Number: 123456

Prepared by Equitable Life of Canada on October 16, 2010

Page 1 of 6

4. GO GREEN WITH PAPERLESS BILLINGS

Our Paperless Billing service offers registered Innovations® Web Services Plan Administrators the option to retrieve their bills within our secure web environment.

Paperless Billing will replace the paper billings that are currently mailed, with an automatic email notification that is sent out when monthly billings are posted to the secure Innovations Plan Administrator web site.

By choosing Paperless Billings, you will benefit from:

- Quicker delivery times and the elimination of mailing delays;
- Secure storage of billings;
- Access to view and print any billings produced within the last 12 month period; and
- A reduction in the amount of paper used to produce monthly billings.

Paperless Billing is simple!

- **Open** the Paperless Billing email which indicates that your current billing is ready;
- **Click** on the direct link to the Innovations site within the email;
- **Log** onto the Innovations site; and
- **Select** and **view** your current billing.

Whether your premium is automatically withdrawn using Pre-Authorized Debit (PAD) or you pay by cheque, Paperless Billing will allow you to view and verify your current billing prior to the scheduled debit withdrawal date or remittance due date.

If you currently pay your premium by cheque and opt for Paperless Billing, simply include the first page of your billing "Premium Statement header page", with your payment and Indicate your policy number on your cheque.

SECTION 3: MANAGING CLAIMS

Please be sure Plan Members include the following information on all of their claims forms before they are submitted to Equitable Life:

- Group Policy Number and Division Number;
- The name of the Policyholder;
- The Plan Member's name;
- The Plan Member's Certificate Number; and
- The Plan Member's full address.

If the claim is for a dependent (spouse/partner or child), the claim should also include the birth date for each dependent.

This information is required before Equitable Life's Claims System can process claims. If this data is not included, the claim form will be returned for completion.

1. PLAN MEMBER LIFE INSURANCE CLAIMS

If an insured Plan Member dies, notify our Group Life and Disability Claims Department as soon as possible. We will send the required forms to you to be completed by the claimant (the beneficiary) and the attending physician (if required). There will also be an **Employer's Statement** for you to complete. Submit the forms to us, along with any other pertinent information.

Your Master Policy may include "**Life Waiver**". Under this clause, an insured Plan Member who is totally disabled may be eligible to have their Plan Member Life Insurance continued at no further cost. For details, please refer to the "Extended Death Benefit" under the Plan Member Life Insurance section in your Group Master Policy, or contact our Group Life and Disability Claims Department. We will provide the necessary forms.

2. DEPENDENT LIFE INSURANCE CLAIMS

If a Plan Member's eligible dependent (spouse/partner or child) dies, please notify our Group Life and Disability Claims Department as soon as possible. The required forms will be sent to you.

3. PLAN MEMBER ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) CLAIMS

Please refer to the "Table of Losses and Benefits" in your Master Policy. If an insured Plan Member suffers any of these losses as a result of an accident, notify our Group Life and Disability Claims Department within 90 days. We will send the required forms to you to be completed by the claimant and the attending physician. Then send to us:

- The completed forms; and
- Any newspaper clippings or police reports concerning the accident.

4. QUICKASSESS

Absence and Accommodation Review Service from Equitable Life of Canada

QuickAssess™ is a fee-for-service that provides an unbiased and timely assessment of the medical information associated with complicated employee absences and workplace accommodation requests. **QuickAssess** can compliment employers' existing Human Resource efforts by providing clarity regarding the medical evidence associated with:

- Chronic or patterned absenteeism;
- Requests to modify work duties or workplaces;
- Return to work coordination; and
- Employment Insurance sick leaves.

All that is required to access this service is the submission of a completed **QuickAssess** Employer Referral Form. This simple form is designed to capture the employer, employee and medical information that Equitable Life requires to complete a thorough assessment. After receiving the completed **QuickAssess** Employer Referral Form, a disability specialist will review the submitted information. Employers will be kept informed of the progress of the review, including communicating when further information may be required to complete the assessment.

For a \$200.00 flat fee, **QuickAssess** provides a:

- Review and assessment of all relevant documentation and medical evidence;
- Telephone interview with the employee (if/as required);
- Telephone call to the employer to discuss the review and any potential recommendations; and
- Written summary of the assessment, including any recommendations.

If an employer requires further support in coordinating third-party ergonomic, medical or other services related to the original **QuickAssess** referral, coordination of these services can be provided at a rate of \$100.00 per hour. Employers will be charged at cost for all authorized, coordinated third party services.

QuickAssess is available for policyholders who:

- Hold an in-force Group Benefits insurance contract with Equitable Life; and
- Do not have a formal Short or Long Term Disability Benefit with any provider other than Equitable Life

*Please note that Workers' Compensation related issues are not eligible for **QuickAssess** and that any salary arrangements during the **QuickAssess** process remain the responsibility of the employer. The employee's medical condition and history will remain confidential.*

5. PLAN MEMBER SHORT TERM DISABILITY (STD) CLAIMS

The Plan Member Becomes Disabled

If a Plan Member is absent from work due to sickness or accident, complete a **SHORT TERM DISABILITY CLAIM FORM 421**, provided the Plan Member:

- Is not eligible to claim under Workers' Compensation (WSIB);
- Will be away from work for at least the length of the STD elimination period specified in your Policy, and
- Is under the care of a Doctor.

To avoid delay in our assessment of each claim:

- Check that you, as the Policyholder, the Plan Member and the attending physician have fully and accurately completed all questions on Form 421;
- Submit the claim to us within seven days of the date the disability began and while the Plan Member is still disabled and absent from work; and
- When submitting the claim to us, please include any information that may help our Claims Department in assessing the claim. (Please refer to Section 3, #7 "Claims Control".)

Benefits become payable at the end of the elimination period, provided the claim has been assessed and approved as of this date. If it has not been approved by this date (usually because the forms are not submitted in time or some information is still outstanding), benefits would become payable retroactively once the claim is processed.

The Short Term Disability premiums are still payable while the Plan Member is collecting benefits.

While the Plan Member remains disabled, a **SUPPLEMENTARY REPORT ON CLAIM FOR DISABILITY BENEFITS** - FORM 422 will be required from time to time. When one is needed, Equitable Life will contact the Plan Member directly. Further benefit payments can be considered once we receive the completed Form 422

NOTE: Plan Members under the care of a Chiropractor or Dentist may be allowed benefits for a limited period of time (up to 4 weeks), even if they are not under the care of a Doctor. The disability must be related to the practitioner's field. The Chiropractor or Dentist treating the Plan Member would then complete FORM 421.

The Plan Member Returns to Work

When the Plan Member returns to work, complete an **ADVICE ON RETURN OF ABSENT EMPLOYEE - FORM 420** and send it to us as soon as possible.

If the Plan Member returns to work and becomes disabled again from the same cause within 14 days of the date of return, a **SHORT TERM DISABILITY CLAIM FORM 421** should be submitted again. Advise us on which days the Plan Member worked. Short Term Disability benefit payments may continue (excluding the time they did work) and the Plan Member would not have to serve another elimination period. However, the Maximum Benefit payable will take into account all amounts that were paid from the original date of disability.

The Plan Member Reaches the Maximum Benefit Period

If the Plan Member reaches the maximum benefit payable, Short Term Disability benefit payments will automatically stop. We will advise the Plan Member in writing with the final claim cheque. If the person remains an employee of your Company, the other benefits can continue under your Group Plan, as long as the Plan Member is disabled. The Short Term Disability benefit, however, will be terminated.

When benefits continue while the Plan Member is disabled, the monthly premiums (except for Short Term Disability) are still payable. Coverage for the Plan Member will terminate according to the terms of your Policy (such as when they reach the Maximum Age for Coverage). If the Plan Member returns to work while still eligible under the Group Plan, submit an **ADVICE ON RETURN OF ABSENT EMPLOYEE - FORM 420** to us within 31 days of the date of return. The Short Term Disability benefit will then be reinstated. If the Plan Member again becomes disabled from the same or related cause(s) within 14 days, the Maximum Benefit Period is still considered to have been reached and no benefits are payable.

For your own protection, we advise that you request a Physician's statement to document that the Plan Member is capable of returning to work on a full-time basis.

Disabled Plan Members who retire or otherwise leave your employ should be treated similarly to a terminated Plan Member as outlined in Section 1, #9 "Terminating a Plan Member's Coverage" of this Guide.

Note: A Plan Member who is receiving STD benefit payments is not eligible for any increases in coverage while they remain disabled. For example, if changes were made to your Group Policy (such as adding a benefit, increasing the maximum or reimbursement percentage for a benefit), the disabled Plan Member (and dependents) will not be eligible for this change until the Plan Member returns to active, full-time work.

6. PLAN MEMBER LONG TERM DISABILITY (LTD) CLAIMS

Eligible Plan Members

Plan Members **under age 65** are eligible to apply for the Long Term Disability benefit. When a Plan Member reaches age 65, coverage automatically terminates and benefit payments will stop.

The Plan Member Becomes Disabled

If a Plan Member is absent from work due to sickness or an accident, and it appears as though they will be away for at least the elimination period for your LTD Plan, then please refer to the **EMPLOYER'S GUIDE ON HOW TO ASSIST AN EMPLOYEE APPLYING FOR LONG TERM DISABILITY BENEFITS - FORM 180**. There is a reference guide for your employee to assist them with applying for LTD benefits. All forms including these 2 guides can be found on our website www.equitable.ca.

Benefits become payable at the end of the elimination period, provided the claim has been assessed and approved by our Disability Specialist as of this date. Long Term Disability monthly premiums are waived while the Plan Member is collecting benefits.

Note: A Plan Member who is receiving LTD benefit payments is not eligible for any increases in coverage while they remain disabled. For example, if changes were made to your Group Policy (such as adding a benefit, increasing the maximum or reimbursement percentage for a benefit), the disabled Plan Member (and dependents) will not be eligible for this change until the Plan Member returns to active, full-time work.

The Plan Member Returns to Work

When the Plan Member returns to work, complete an **ADVICE ON RETURN OF ABSENT EMPLOYEE - FORM 420** and send it to us as soon as possible.

If the Plan Member returns to work and becomes disabled again from the same cause within six months of the date of return and wished to pursue a recurrence of their LTD claim, please refer to the Employer's Guide on How to Submit an LTD application at www.equitable.ca. The Plan Member will not have to serve another elimination period. However, the Maximum Benefit payable will take into account all amounts that were paid from the original date of disability.

Rehabilitation

Benefits will not be payable if the Plan Member performs any work for wage without the approval of the Group Life & Disability Claims Department prior to the work being done. If a Plan Member has partly recovered, they may be able to return to work on a part-time basis. Send the full details to us, including the number of hours per week that can be worked, the number of hours the Plan Member did work in a month, medical verification, and the rate of remuneration paid. Our Disability Specialist will consider the request on a case-by-case basis and will advise you if the Plan Member qualifies for partial benefits as part of a rehabilitation program.

7. CLAIMS CONTROL (STD and LTD)

We are in the business of paying legitimate claims and recognize the importance for your Plan Members of having financial support while they are recovering from a disability.

As an employer, you can influence the duration of a disability claim by:

- Reporting all claims as soon as possible;
- Providing accommodated work; and
- Providing information about your work place and having up to date job descriptions or physical demands analysis of your jobs, if available.

REMEMBER: The premium rates for your Group Plan are partly based on your Plan Members' claims experience. It is in the best interest of both Equitable Life and you to work together to manage a claim to successful resolution.

8. EXTENDED HEALTH BENEFITS CLAIMS

Hospital Claims

The Hospital provides a completed claim form for the Plan Member. Please make sure the claim form includes:

- The Group Policy Number;
- The Plan Member's name and Certificate Number;
- The patient's name and full date of birth;
- The date of admission and date of discharge from the hospital; and
- The Plan Member's signature.

Unless other procedures have been arranged, a cheque will be sent to the Plan Member. However, if the Plan Member **assigned** the claim form to the hospital, we will send the cheque directly to that hospital.

Drug Claims

If you do not have a Pay-Direct drug plan:

The Plan Member should complete and sign an **EXTENDED HEALTH CARE CLAIM FORM 466** and be sure to attach the original receipts from the Pharmacy.

Please ask your Plan Members to save their Drug claims and receipts until they exceed any Deductible Amount under your Plan.

If you know that someone also has Drug Plan coverage elsewhere, make sure this is indicated on the claim form so benefits can be co-ordinated properly between the two Plans (see Section 2, #5 c) Coordination of Benefits for Health and Dental below).

See Section 1, #16 “Special Instructions if you have a Pay Direct Drug Plan”, of this Manual for more information concerning Pay-Direct Drug Plans and "No-Card" Drug Plans.

If you have a Pay-Direct drug plan that includes a Group Benefits Drug Card:

When Plan Members or their dependents are able to use the drug card at a pharmacy, there is no drug claim to be submitted. If the person was unable to fill the prescription using the drug card and had to pay the full cost of the prescription at the pharmacy, the prescription receipt must be sent directly for reimbursement to the Pay Direct provider. The receipt should be attached to an **EMPLOYEE REIMBURSEMENT FORM FOR PAY DIRECT DRUG CARD CLAIMS - FORM 466PD**, which you can access via our website at www.equitable.ca. Please do not send the claim to Equitable Life as we will have to forward it to the Pay Direct provider and this will delay the payment. Please send the claim directly to the Pay Direct provider.

If you have a Pay-Direct drug plan that does not include a Group Benefits Drug Card:

If you have a “no-card” plan (where the Plan Member/dependent has the prescription filled using a mail-order pharmacy, such as MediTrust), the original receipt should be sent to Equitable Life, along with an **EXTENDED HEALTH CARE FORM 466**.

Vision Care Claims

If your Vision Care plan specifies that expenses are eligible only if there has been a change in prescription, then the detailed receipt from the supplier (showing the change in prescription) should be submitted along with our **EXTENDED HEALTH CARE CLAIM FORM 466**. The Plan Member (or dependent) should give this form to their supplier to complete the appropriate section.

If your Vision Care plan does not require that there be a change in prescription in order for the expenses to be eligible, submit the receipt with an **EXTENDED HEALTH CARE CLAIM FORM 466**. A cheque will be sent to the Plan Member.

Other Health Claims

Other expenses eligible under the Extended Health Benefit are listed in your Policy. These would include items such as Private Duty Nursing, Appliances and Supplies such as hearing aids and orthotics etc, Paramedical Services, etc.

The Plan Member should complete an **EXTENDED HEALTH CARE CLAIM FORM 466** and be sure it includes full details, including:

- The Plan Member's name and Certificate Number;
- The type of service;
- The date(s) of service;
- The Physician's prescription (where required) and the charges; and
- The Plan Member's signature.

A cheque and explanation of benefits will be sent to the Plan Member's home address. We also offer Direct Deposit (Electronic Funds Transfer) where funds can be electronically deposited into Plan Members' bank accounts. Contact our Health Claims Customer Service department for further details or submit a **GROUP PLAN MEMBER CHANGE FORM 438 Section F**.

NOTE: In the case of terminated policies, claims must be submitted within ninety days of the effective date of the termination date of the policy.

NOTE: If the policy is Administrative Services Only (ASO), then claims payment stops on the date of termination. Claims received at Equitable Life's Head Office on or before the termination date will be processed and paid as appropriate under the policy. Any claims not received at Equitable Life by that date are not eligible for payment, regardless of the date incurred; claims received after that date will be returned.

If your plan is moving to a new group plan provider, those claims should be submitted to the new carrier.

9. DENTAL CLAIMS

Use our **STANDARD DENTAL CLAIM FORM 520**. Most dental offices provide the form directly to Plan Members. To avoid delay in claim payment, please ensure that all information is complete.

If a claim is submitted with incorrect or missing information, delays in payment can occur.

Part 1: This is completed by the Dentist.

Part 2: This is completed by the Dentist/Insured.

Part 3: This is completed by the Dentist/Insured.

In order to receive prompt payment, be sure the Plan Member has signed in the appropriate spaces on the forms.

Finally, please be sure that your Group Policy Number and the Plan Member's certificate/I.D. number are provided on all claim forms.

All Claims Cheques and explanation of benefits are sent directly to the insured's home address. However, if the Plan Member **assigned** the claim, payment will be made directly to the Dentist.

NOTE: Claims for dental accidents are paid under the Major Services section of the Extended Health Benefits, not under the Dental Benefits. If your Group Plan with Equitable Life includes Major Services, please submit any claims for dental accidents using a **STANDARD DENTAL CLAIM FORM 520**.

Electronic Dental Claims Submission (EDI Dental)

Equitable Life is able to accept dental claims electronically directly from Dental offices that utilize the Canadian Dental Association network (CDAnet). For those Dentists utilizing the CDAnet, claims will be routed to Equitable Life via the CDA network. The CDAnet will perform basic validation of the claim form to ensure proper completion prior to transmitting the information to Equitable Life. The Dentist will receive a message from the provider indicating receipt of the claim information on behalf of Equitable Life. However, adjudication of claims eligibility and amount payable will not be determined on-line or in real time to the Dentist.

Equitable Life will then process claims not requiring additional information, such as x-rays, according to our normal adjudication practices. Payments not assigned to Dentists will be mailed directly to the insured's home address.

NOTE: In the case of terminated policies, claims must be submitted within ninety days of the effective date of the termination date of the policy.

Please note: if the policy is Administrative Services Only (ASO), then claims payment stops on the date of termination. Claims received at Equitable Life's Head office on or before the termination date will be processed and paid as appropriate under the policy. Any claims not received at Equitable Life by that date are not eligible for payment, regardless of the date incurred; claims received after that date will be returned.

If your plan is moving to a new group plan provider, those claims should be submitted to the new carrier.

10. DIRECT DEPOSIT FOR CLAIMS CHEQUES (ELECTRONIC FUNDS TRANSFER)

Plan Members are able to take advantage of direct deposit for all Health, Dental and Disability claims (except for pay direct drug claims).

If your Plan Members wish to make use of this service, we will require the completion of the **FORM 190 – AUTHORIZATION FOR DIRECT DEPOSIT FORM** to enable us to deposit claim cheques directly into the bank account of their choosing. In addition, we will also require a VOID cheque or stamped bank document. Please be assured that all banking information is stored in a secure area and is kept in the strictest of confidence. The completed signed form and VOID cheque or stamped bank document can be sent to Group Claims either with the next claim or in advance of future claims.

Your Plan Member will continue to receive an Explanation of Benefits. Once the claim has been adjudicated, the eligible claim amount will be deposited into the specified account within 2-3 business days. If banking information changes, we must be notified immediately. If a claim is submitted and the banking information is incorrect, the bank will reject the deposit and we will process a manual cheque and continue to process manual cheques until the banking information is updated.

11. COORDINATION OF BENEFITS FOR HEALTH AND DENTAL

If a Plan Member and his/her spouse both have family coverage under their respective Group Plans, they may submit claims to both insurers to receive the maximum possible reimbursement (up to 100%). (See Section 1, #4 "When Can a Plan Member Opt Out of Benefits" of this Manual for an explanation of the Coordination of Benefits provision, and further information on submitting claims.)

Plan Member and Spouse:

Both the Plan Member and spouse should first submit their own claims through their own Plan. Any unpaid balance is then submitted to the other spouse's insurer for payment. Be sure to include the proper Claim Form and the Explanation of Benefits (included with their cheques from the first insurer) because the first carrier will keep the original receipts.

Dependent Children:

Submit claims first to the Plan of the parent whose birthday is the earliest in the calendar year (e.g. Dad's date of birth is February 1 and Mom's date of birth is August 6, claims would be submitted to Dad's plan first).

12. SPECIAL CLAIMS SERVICES (COST PLUS)

The Special Claims Services (also called "Cost Plus") allows the Policyholder to authorize Equitable Life to make Health and/or Dental claim payments that would not normally be eligible under the regular terms of the Policy. A special claim form is required and we charge an administration fee for each claim paid. The "Special Claims Services" page must be part of your Master Policy before such claims can be eligible.

The Policyholder must choose whether Special Claims Services is to be made available for all Plan Members or only for a specific class. We must be advised of your intentions in writing. It is very important that the Policyholder adhere to this decision. For example, Special Claims Services might be made available for all Managers. If a claim is submitted for one Manager, but the Policyholder does not allow a similar claim for another Manager, this is contrary to the terms of the agreement. If this were to happen, the Canada Revenue Agency may treat the situation unfavourably for tax reporting purposes.

For Group Policies that issued with Equitable Life after July 1991, Special Claims Services is included in your Policy (unless your Policyholder specified otherwise). Unless otherwise specified by the Policyholder, the provision applies to all Plan Members.

For Group Policies that issued with Equitable Life prior to July 1991 check your Master Policy to see if your Policyholder has asked us to amend the Policy. When we issue an Endorsement to add Special Claims Services to the Policy, it is presumed to apply for all Plan Members, unless your Policyholder specified otherwise.

Claim forms for Special Claims Services are not included in your administration kit. Please contact your Group Marketing Manager when needed and they will send the appropriate form to you.

Please be advised, a separate cheque should be sent to Equitable Life with the special claim form. Please do not include the dollar amount for the special claim in your premium cheque.

Mail to:

**The Equitable Life Insurance Company of Canada
Attn: Group Health Claims Department
One Westmount Road North
P.O. Box 1603 Station Waterloo
Waterloo, Ontario N2J 4C7**

13. SUMMARY OF HOW TO MAKE A CLAIM

Plan Member Life and Dependent Life Claims

Claim Form: Will be supplied by Equitable once you advise us of the death.
Time Limit: Notify us as soon as possible.

Plan Member Accidental Death and Dismemberment Claims

Claim Form: Will be supplied by Equitable once you advise us of the accident.
Time Limit: Notify us as soon as possible (but within ninety days of the accident).

Plan Member Short Term Disability Claims

Claim Form: Short Term Disability Claim Form 421.
Time Limit: Submit Form 421 to us within seven days from the date of disability.

Plan Member Long Term Disability Claims

Claim Form: See Employer's Guide on How to Assist an Employee Applying for Long Term Disability Benefits Form 180 and Employee's Guide - How to submit a Long Term Disability Claim Form 181
Time Limit: Submit forms indicated in guides at least eight weeks prior to the end of the Long Term Disability waiting period

Hospital Claims

Claim form: Will be supplied by the hospital.
Time Limit: The claim form should be submitted to us within ninety days of the patient's release from the hospital.

In some provinces, the hospital will send the claim directly to us.

Drug Claims

Claim Form: Supplementary Health Benefits Claim Form 466
Time Limit: Submit Supplementary Health Benefits Claim Form 466 to us within one year of the date of purchase.

Except: Employee Reimbursement Form For Pay Direct Drug Card Claims - Form 466PD is to be sent directly to the Pay Direct provider, if you have a pay-direct drug card that has not been accepted at the pharmacy.

Vision Care Claims

Claim form: **EXTENDED HEALTH CARE CLAIM FORM 466** plus the supplier's detailed receipt showing a change in prescription if required under your plan.
Time Limit: Submit the appropriate form to us within ninety days of the date of service.

Other Health Claims

Claim form: **EXTENDED HEALTH CARE CLAIM FORM 466**
Time Limit: Submit **EXTENDED HEALTH CARE CLAIM FORM 466** (and the Doctor's prescription, where required) to us within ninety days of the date of treatment.

Dental Claims

Claim form: **STANDARD DENTAL CLAIM - FORM 520**
Time limit: Submit Form 520 to us within ninety days of the date of treatment.

14. HELPFUL TIPS ON COMPLETING CLAIM FORMS

When claims are submitted correctly, they can be processed promptly. However, if important information is missing, the claim may have to be sent back for completion, delaying payment. While we go to great lengths not to return claims, it cannot always be avoided.

We thought you might find it helpful to know some of the reasons why claim forms might have to be returned, so you can watch for them and help us provide excellent claims service to you and your Plan Members.

In some cases, the problem can be as simple as forgetting to **include the Group Policy Number and Plan Member's Certificate Number**.

Short Term Disability and Long Term Disability

When a claim is submitted, we require current salary information (including deductions, if your Plan is non-taxable). Please be sure to include salary information since it is used to calculate benefit amounts. We are unable to process the claim without accurate salary information.

If the disability is due to an accident (such as a motor vehicle accident or a fall, etc.), please advise us of any information you may have regarding the accident. Any information that you can provide helps us in determining the waiting period that must be satisfied before benefit payments can commence.

For ongoing claims, we occasionally ask that a Supplementary Form 422 be completed. It includes three sections to be completed (one by the Plan Member, one by the physician, and one by you as the Policyholder).

Health and Dental

We require the date of birth of all dependents (spouse and/or children) and FULL ADDRESS submitted for all claims. Our claims-paying system keeps track of dependents by their dates of birth. In order to maintain records (such as most recent visits to the Dentist and plan maximums), we require this information on each and every claim. It is also very important that dependents' dates of birth are correct.

We require the information concerning school-age children on each claim. A dependent's situation may change from claim to claim. For example, a 20-year-old child may be attending university and not working full-time on one claim and then have left school and be working full-time when the next claim is submitted.

If the insured Plan Member is taking advantage of the Coordination of Benefits provision, please ensure that the information is included on the claims information submitted. All Canadian insurance companies follow certain rules to ensure that all claims are handled in the same manner (see Section 3, #10 "Coordination of Benefits for Health and Dental" and Section 1, #4 "When Can a Plan Member Opt Out of Benefits"). The rules ensure that one insurer does not carry all of the claims for a family that has other coverage. It also prevents Plan Members from claiming twice and being paid twice for the same services.

15. EZCLAIM

Equitable Life offers two new easy alternate methods for submitting Health and Dental claims, *EZClaim®* Mobile and Online. Paired with Direct Deposit and electronic Explanation of Benefits (eEOB), *EZClaim* Mobile or Online delivers the fastest claims processing and Plan Members will usually receive payments within 2-3 days of submitting their claim.

***EZClaim* Mobile**

Plan members can submit claims from their smartphone with the *EZClaim* Mobile App available for Apple, Android and BlackBerry devices. Plan members can download the free app and follow the prompts to submit a claim electronically to Equitable Life for payment. Payment is usually deposited within 2-3 days into the Plan Member's account.

EZCLAIM Online

Plan members can submit claims from their secure EquitableHealth.ca web account. Plan members can sign into their account, click on EZClaim and fill out the online interactive form to submit claims to Equitable Life. Payment is usually deposited within 2-3 days into the Plan Member's account.

Please note that whichever way the plan member chooses to submit their Health and Dental claims, they will always need to submit their receipts at the same time. If we do not receive the completed electronic claims form and receipts at the same time, we will not be able to process their claim.

Works for me.®

Canadians have turned to Equitable Life since 1920 to protect what matters most. We work with independent advisors across Canada to offer individual insurance, savings and retirement and group benefits solutions to meet your needs.

But we're not your typical financial services company. We have the knowledge, experience and ability to find solutions that work for you. We're friendly, caring and interested in helping. And we're owned by our participating policyholders, not shareholders. So we can focus on your interests and provide you with personalized service, security and wellbeing.



One Westmount Road North,
Waterloo, Ontario N2J 4C7
Visit our website: www.equitable.ca

® or ™ denotes a trademark of The Equitable Life Insurance Company of Canada.