Sun Life Financial

your group benefits

Rolls-Royce Canada Limited

Retirees
Divisions 901, 902, 913 and 923

Contract Number 50941 Part B
Effective May 23, 2013

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Notice from Rolls Royce

Rolls-Royce reserves the right to amend or terminate the Group Insurance Program at retirement at any time, and to amend the Program's cost-sharing provisions, subject to a 30-day written notice.

General Information

About this booklet

The information in this retirees' benefits booklet is important to you and should be kept in a safe place. It provides the information you need about the group benefits available through Rolls-Royce Canada's group contract with Sun Life.

If you have any questions about the information in this retirees' benefits booklet, or if you need additional information about your group benefits, please contact Sun Life.

Eligibility

To be eligible for group benefits, you must be a resident of Canada and meet the following conditions:

- you are at least 55 years of age, and have completed at least 10 years of employment with Rolls-Royce Canada and are retired from active employment.
- you were covered on the day immediately preceding your retirement.

There is no waiting period for your group plan.

Your dependents become eligible for coverage on the date you become eligible or the date they first become your dependent, whichever is later. You must apply for coverage for yourself in order for your dependents to be eligible.

Who qualifies as your dependent

Your dependent must be your spouse or your child and a resident of Canada.

Your spouse by marriage or under any other formal union recognized by law, or your partner of the opposite sex or of the same sex who has been publicly represented as your spouse and with whom you have been cohabiting for at least the last year (or less if a child is born out of your relationship), is an eligible dependent. You can only cover one

spouse at a time.

Your children and your spouse's children (other than foster children) are eligible dependents if they are not married or in any other formal union recognized by law, and are under age 21.

A child who is a full-time student attending an educational institution recognized under the Income Tax Act (Canada) is also considered an eligible dependent until the age of 26 as long as the child is entirely dependent on you for financial support.

If a child becomes handicapped before the limiting age, we will continue coverage as long as:

- the child is incapable of financial self-support because of a physical or mental disability, and
- the child depends on you for financial support, and is not married nor in any other formal union recognized by law.

In these cases, you must notify Sun Life within 31 days of the date the child attains the limiting age. We can give you more information about this.

Enrolment

You have to enrol to receive coverage. To enrol, you must send the appropriate enrolment information to Sun Life within 31 days after the date you retired. For a dependent to receive coverage, you must request dependent coverage.

When coverage begins

Your coverage begins on the date you become eligible for coverage.

Dependent coverage begins on the date your coverage begins or the date you first have an eligible dependent, whichever is later.

However, for a dependent, other than a newborn child, who is hospitalized, coverage will begin when the dependent is discharged from hospital and is actively pursuing normal activities.

Once you have dependent coverage, any subsequent dependents will be

covered automatically, as soon as you advise Sun Life.

If there are additional conditions for a particular benefit, these conditions will appear in the appropriate benefit section later in this booklet.

Changes affecting your coverage

From time to time, there may be circumstances that change your coverage.

For example, Rolls-Royce Canada may change the group contract. Any resulting change in the coverage will take effect on the date of the change in circumstances.

The following exception applies if the result of the change is an increase in coverage:

If you or a dependent, other than a newborn child, are hospitalized on the date when the change occurs, the change in your coverage or your dependent's coverage cannot take effect before you or your dependent are discharged and are actively pursuing normal activities.

Updating your records

To ensure that coverage is kept up-to-date, it is important that you report any of the following changes to Sun Life:

- change of dependents.
- change of name.
- change of beneficiary.

Accessing your records

As required by legislation, for insured benefits, if you reside in Alberta or British Columbia, you may obtain copies of the following documents:

- your enrolment form or application for insurance.
- any written statements or other record, not otherwise part of the application, that you provided to Sun Life as evidence of insurability.

For insured benefits, on reasonable notice, you may also request a copy of the contract.

The first copy will be provided at no cost to you but a fee may be charged for subsequent copies.

All requests for copies of documents should be directed to one of the following sources:

- our website at www.mysunlife.ca.
- our Customer Care centre by calling toll-free at 1-866-881-0583.

When coverage ends

As a retiree, your coverage will end on the earlier of the following dates:

- the date you no longer meet the eligibility requirements.
- the end of the period for which premiums have been paid to Sun Life for your coverage.
- the date the group contract ends.

A dependent's coverage terminates on the earlier of the following dates:

- the date your coverage ends.
- the date the dependent is no longer an eligible dependent.
- the end of the period for which premiums have been paid for dependent coverage.

The termination of coverage may vary from benefit to benefit. For information about the termination of a specific benefit, please refer to the appropriate section of this retirees' benefits booklet.

Surviving dependent coverage

If you die while covered by this plan, coverage for your dependents will continue, without premiums, until the earlier of the following dates:

- for persons residing in Québec, for drugs listed in the Régie de l'assurance-maladie du Québec (RAMQ) drug formulary, 24 months after the date of your death.
- the date the person would no longer be considered your dependent under this plan if you were still alive.
- the date the benefit provision under which the dependent is covered terminates.

Replacement coverage

The group contract will be interpreted and administered according to all legislation concerning the continuation of insurance following contract termination and the replacement of group insurance.

Sun Life will not be responsible for paying benefits if an insurer under a previous group contract is responsible for paying similar benefits.

Making claims

Sun Life is dedicated to processing your claims promptly and efficiently. You should contact Sun Life to get the proper form to make a claim.

There are time limits for making claims. These limits are discussed in the appropriate sections of this employee benefits booklet. If you fail to abide by these time limits, you may not be entitled to some or all benefit payments.

All claims must be made in writing on forms approved by Sun Life.

For the assessment of a claim, Sun Life may require medical records or reports, proof of payment, itemized bills, or other information Sun Life considers necessary. Proof of claim is at your expense.

Legal actions

Except where or when applicable legislation permits the use of a different limitation period, every action or proceeding against an insurer for the recovery of insurance money payable under this contract is absolutely barred unless commenced within the time set out in the Insurance Act or the time set out in such other legislation as may apply to a claim, action or proceeding for insurance money.

Where or when applicable legislation permits the use of a different

limitation period, no legal action or proceeding may be brought against Sun Life:

- regarding any claims for which no payment has been made by Sun Life, more than one year after the end of the time period in which the initial submission of proof of claim is required by the terms of the contract, or
- regarding claims for which some payment has been made by Sun Life, more than one year after the last payment made by Sun Life with respect to the claim.

Coordination of benefits

If you or your dependents are covered for Extended Health Care under this plan and for Extended Health Care or Dental Care and another plan, our benefits will be coordinated with the other plan following insurance industry standards. These standards determine which plan you should claim from first.

The plan that does not contain a coordination of benefits clause is considered to be the first payer and therefore pays benefits before a plan which includes a coordination of benefits clause.

For dental accidents, health plans with dental accident coverage pay benefits before dental plans.

The maximum amount that you can receive from all plans for eligible expenses is 100% of actual expenses.

Where both plans contain a coordination of benefits clause, claims must be submitted in the order described below.

Claims for you and your spouse should be submitted in the following order:

- the plan where the person is covered as an employee. If the person is an employee under two plans, the following order applies:
  - the plan where the person is covered as an active full-time employee.

  - the plan where the person is covered as an active part-time employee.
  - the plan where the person is covered as a retiree.
- the plan where the person is covered as a dependent.

Claims for a child should be submitted in the following order:

- the plan where the child is covered as an employee.
- the plan where the child is covered under a student health or dental plan provided through an educational institution.
- the plan of the parent with the earlier birth date (month and day) in the calendar year. For example, if your birthday is May 1 and your spouse's birthday is June 5, you must claim under your plan first.
- the plan of the parent whose first name begins with the earlier letter in the alphabet, if the parents have the same birth date.

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

- the plan of the parent with custody of the child.
- the plan of the spouse of the parent with custody of the child.
- the plan of the parent not having custody of the child.
- the plan of the spouse of the parent not having custody of the child.

When you submit a claim, you have an obligation to disclose to Sun Life all other equivalent coverage that you or your dependents have.

Sun Life can help you determine which plan you should claim from first.

Medical examination

We can require you to have a medical examination if you make a claim for benefits. We will pay for the cost of the examination. If you fail or refuse to have this examination, **we will not pay** any benefit.

Recovering overpayments

We have the right to recover all overpayments of benefits either by deducting from other benefits or by any other available legal means.

Definitions

Here is a list of definitions of some terms that appear in this retirees' benefits booklet. Other definitions appear in the benefit sections.

Accident An accident is a bodily injury that occurs solely as a direct result of a violent, sudden and unexpected action from an outside source.

Doctor A doctor is a physician or surgeon who is licensed to practice medicine where that practice is located.

Illness An illness is a bodily injury, disease, mental infirmity or sickness. Any surgery needed to donate a body part to another person which causes total disability is an illness.

We, our and us We, our and us mean Sun Life Assurance Company of Canada.

Extended Health Care
(Medicare Supplement)

General description of the coverage

In this section, *you* means the retiree and all dependents covered for Extended Health Care benefits.

Extended Health Care coverage pays for eligible services or supplies for you that are medically necessary for the treatment of an illness.

To qualify for this coverage you must be entitled to benefits under a provincial medicare plan or federal government plan that provides similar benefits. If you leave your province of residence for period longer than the maximum period authorized by your province of residence (normally 6 months), you will need to re-apply for coverage under a provincial/federal plan that provides similar benefits in order to quality for coverage under the Extended Health Care benefit.

An expense must be claimed for the benefit year in which the expense is incurred. You incur an expense on the date the service is received or the supplies are purchased or rented.

The benefit year is from January 1 to December 31.

Deductible

The deductible is the portion of claims that you are responsible for paying.

The deductible is $25 each benefit year per family.

After the deductible has been paid, claims will be paid up to the percentage of coverage under this plan.

Lifetime maximum benefit

Under Extended Health Care, for all eligible expenses combined, the maximum amount we will pay for retired employees and their dependents after retirement is $50,000 per person.

There is an automatic reinstatement each benefit year of up to $1,000

of benefits paid but not previously reinstated. This reinstatement will be made on the first day of each benefit year.

Prescription drugs

We will cover the cost of the following drugs and supplies that are prescribed by a doctor or dentist and are obtained from a pharmacist. Drugs covered under this plan must have a Drug Identification Number (DIN) in order to be eligible.

- drugs that legally require a prescription.
- life-sustaining drugs that may not legally require a prescription.
- injectable drugs and vitamins.
- compounded preparations, provided that the principal active ingredient is an eligible expense and has a DIN.
- diabetic supplies.
- products to help a person quit smoking that legally require a prescription, up to the maximum established under the Québec drug insurance plan.
- drugs for the treatment of infertility, up to a lifetime maximum of $2,400 for each person.
- for **hourly retirees under age 65 (division 923)**, vaccines that legally require a prescription.
- for **all retired employees, other than hourly retirees under age 65 (division 923)**, vaccines.
- intrauterine devices (IUDs) and diaphragms.
- colostomy supplies.
- varicose vein injections.

We will cover 100% of the cost of the above drugs and supplies after you pay the deductible.

For **hourly retirees under age 65 (division 923)**, payments for any single purchase are limited to quantities that can reasonably be used in a 34 day period or, in the case of certain maintenance drugs, in a 100 day period as ordered by a doctor. For **all retired employees, other than hourly retirees under age 65 (division 923)**, we will only pay for quantities that can reasonably be used in a 3 month period.

We will not pay for the following, even when prescribed:

- infant formulas (milk and milk substitutes), minerals, proteins, vitamins and collagen treatments.
- the cost of giving injections, serums and vaccines.
- treatments for weight loss, including drugs, proteins and food or dietary supplements.
- hair growth stimulants.
- drugs for the treatment of sexual dysfunction.
- drugs that are used for cosmetic purposes.
- natural health products, whether or not they have a Natural Product Number (NPN).
- drugs and treatments, and any services and supplies relating to the administration of the drug and treatment, administered in a hospital, on an in-patient or out-patient basis, or in a government-funded clinic or treatment facility.

Also, **we will not pay for:**

- **any drugs payable entirely or in part** by the Régie de l'assurance-maladie du Québec (RAMQ) for persons age 65 and over covered by the RAMQ drug insurance plan.
- **any drug charge**, including dispensing fee, a person age 65 or over has to pay under the Ontario Drug Benefit Program.

Québec drug insurance plan

For retirees residing in Québec, any conditions under this plan that do not meet the requirements under the Québec drug insurance plan are automatically adjusted to meet those requirements.

Persons age 65 or over

When a person age 65 or over is eligible for coverage under a provincial drug insurance plan, Sun Life assumes that the person is participating in that plan. However, if the employee is the first to reach age 65, Sun Life assumes that his dependents are also participating in the provincial drug insurance plan. We will not pay any drugs payable entirely or in part by your provincial drug insurance plan.

Please contact Sun Life if you have any questions.

Other health professionals allowed to prescribe drugs

We reimburse certain drugs prescribed by other qualified health professionals the same way as if the drugs were prescribed by a doctor or a dentist if the applicable provincial legislation permits them to prescribe those drugs.

Hospital expenses in your province

We will cover 100% of the costs for hospital care in the province where you live. The deductible does not apply to these expenses.

We will cover, up to a maximum of 120 days for treatment of an illness due to the same or related causes:

- out-patient services in a hospital, except for any services explicitly excluded under this benefit.
- the difference between the cost of a ward and a semi-private hospital room.
- the difference between the cost of a semi-private and a private hospital room, up to a maximum of $15 per day.

We will also cover the cost of room and board in a convalescent hospital if this care has been ordered by a doctor as long as:

- it follows at least 3 consecutive days of in-patient hospitalization,
- it begins within 14 days of release from the hospital, and

- it is primarily for rehabilitation, and not for custodial care.

The maximum amount payable is the difference between the cost of a ward and a semi-private room up to a maximum of 180 days for treatment of an illness due to the same or related causes.

For purposes of this plan, a *convalescent hospital* is a facility licensed to provide convalescent care and treatment for sick or injured patients on an in-patient basis. Nursing and medical care must be available 24 hours a day. It does not include a nursing home, rest home, home for the aged or chronically ill, sanatorium or a facility for treating alcohol or drug abuse.

A *hospital* is a facility licensed to provide care and treatment for sick or injured patients, primarily while they are acutely ill. It must have facilities for diagnostic treatment and major surgery. Nursing care must be available 24 hours a day. It does not include a nursing home, rest home, home for the aged or chronically ill, sanatorium, convalescent hospital or a facility for treating alcohol or drug abuse or beds set aside for any of these purposes in a hospital.

Expenses out of your province

We will cover emergency services while you are outside the province where you live. We will also cover referred services.

For both emergency services and referred services, we will cover the cost of:

- a semi-private hospital room.
- other hospital services provided outside of Canada.
- out-patient services in a hospital.
- the services of a doctor.

Expenses for all other services or supplies eligible under this plan are also covered when they are incurred outside the province where you live, subject to the reimbursement level and all conditions applicable to those expenses.

Emergency services

We will pay 100% of the cost of covered emergency services after you pay the deductible.

We will only cover emergency services obtained within 60 days of the date you leave the province where you live. If hospitalization occurs within this period, in-patient services are covered until the date you are discharged.

Emergency services mean any reasonable medical services or supplies, including advice, treatment, medical procedures or surgery, required as a result of an emergency. When a person has a chronic condition, emergency services do not include treatment provided as part of an established management program that existed prior to the person leaving the province where the person lives.

Emergency means an acute illness or accidental injury that requires immediate, medically necessary treatment prescribed by a doctor.

At the time of an emergency, you or someone with you must contact Sun Life's Emergency Travel Assistance provider, Europ Assistance USA, Inc. (*Europ Assistance*). All invasive and investigative procedures (including any surgery, angiogram, MRI, PET scan, CAT scan), must be pre-authorized by Europ Assistance prior to being performed, except in extreme circumstances where surgery is performed on an emergency basis immediately following admission to a hospital.

If contact with Europ Assistance cannot be made before services are provided, contact with Europ Assistance must be made as soon as possible afterwards. If contact is not made and emergency services are provided in circumstances where contact could reasonably have been made, then Sun Life has the right to deny or limit payments for all expenses related to that emergency.

An emergency ends when you are medically stable to return to the province where you live.

As soon as Europ Assistance is notified that you have a medical emergency, its staff, or a physician designated by Europ Assistance,

will, when necessary, attempt to establish communications with the attending medical personnel to obtain an understanding of the situation and to monitor your condition. If necessary, Europ Assistance will also guarantee or advance payment of the expenses incurred to the provider of the medical service.

Europ Assistance may determine, in consultation with an attending physician, that it is necessary for you to be transported under medical supervision to a different hospital or treatment facility or to be sent home. In these cases, Europ Assistance will arrange, guarantee, and if necessary, advance the payment for your transportation.

Sun Life or Europ Assistance, based on available medical evidence, will make the final decision whether you should be moved, when, how and to where you should be moved and what medical equipment, supplies and personnel are needed.

You do not have to send claims for doctors' or hospital fees to your provincial medicare plan first. This way you receive your refund faster. Sun Life and Europ Assistance coordinate the whole process with most provincial plans and all insurers, and send you a cheque for the eligible expenses. Europ Assistance will ask you to sign a form authorizing them to act on your behalf.

If you are covered under this group plan and certain other plans, we will coordinate payments with the other plans in accordance with guidelines adopted by the Canadian Life and Health Insurance Association. The plan from which you make the first claim will be responsible for managing and assessing the claim. It has the right to recover from the other plans the expenses that exceed its share.

Emergency services excluded from coverage

Any expenses related to the following emergency services are not covered:

- services that are not immediately required or which could reasonably be delayed until you return to the province where you live, unless your medical condition reasonably prevents you from returning to that province prior to receiving the medical services.

- services relating to an illness or injury which caused the emergency, after such emergency ends.
- continuing services, arising directly or indirectly out of the original emergency or any recurrence of it, after the date that Sun Life or Europ Assistance, based on available medical evidence, determines that you can be returned to the province where you live, and you refuse to return.
- services which are required for the same illness or injury for which you received emergency services, including any complications arising out of that illness or injury, if you had unreasonably refused or neglected to receive the recommended medical services.
- where the trip was taken to obtain medical services for an illness or injury, services related to that illness or injury, including any complications or any emergency arising directly or indirectly out of that illness or injury.

Referred services

Referred services must be for the treatment of an illness and ordered in writing by a doctor located in the province where you live. We will pay 100% of the costs of referred services after you pay the deductible. Your provincial medicare plan must agree in writing to pay benefits for the referred services.

All referred services must be:

- obtained in Canada, if available, regardless of any waiting lists, and
- covered by the medicare plan in the province where you live.

However, if referred services are not available in Canada, they may be obtained outside of Canada.

Medical services and equipment

We will cover 100% of the costs, after you pay the deductible, for the medical services listed below when ordered by a doctor (the services of a dentist do not require a doctor's order).

- out-of-hospital private duty nurse services when medically necessary. Services must be for nursing care, and not for custodial care. The private duty nurse must be a nurse, or nursing assistant who is licensed, certified or registered in the province where you live and who does not normally live with you. The services of a registered nurse are eligible only when someone with lesser qualifications cannot perform the duties. There is a limit of $10,000 per person per benefit year.

- transportation in a licensed ambulance, if medically necessary, that takes you to and from the nearest hospital that is able to provide the necessary medical services.

- transportation in a licensed air ambulance, if medically necessary, that takes you to the nearest hospital that provides the necessary emergency services.

- the following diagnostic services rendered out of a hospital, except if the covered person's provincial plan prohibits payment of these expenses:

  - laboratory tests.

  - ultrasounds.

  - x-rays, electrocardiograms, mammographies and thermographies, up to a combined maximum of $1,000 per person in a benefit year.

  - Magnetic Resonance Imaging (M.R.I.) and tomography (Scan), up to a combined maximum of 2 tests per person per benefit year.

- dental services, including braces and splints, to repair damage to natural teeth caused by an accidental blow to the mouth that occurs while you are covered. These services must be received within 12 months of the accident. We will not cover more than the fee stated in the Dental Association Fee Guide for a general practitioner in the province where the retiree lives. The guide

must be the current guide at the time that treatment is received.

- wigs following chemotherapy, up to a lifetime maximum of $200 per person. Wigs do not require a doctor's order.
- medically necessary equipment rented, or purchased at our request, that meets your basic medical needs. If alternate equipment is available, eligible expenses are limited to the cost of the least expensive equipment that meets your basic medical needs. For expenses incurred for a wheelchair, coverage is limited to the use of a manual wheelchair, except if the person's medical condition warrants the use of an electric wheelchair.
- casts, splints, trusses, braces or crutches.
- breast prostheses required as a result of surgery, up to a maximum of one prosthesis per person per benefit year and up to a maximum of 2 surgical brassieres per person per benefit year.
- artificial limbs and eyes, including myoelectric appliances (and their repairs) up to a maximum of $10,000 per prosthesis. Repair charges **are not** included in this maximum.
- stump socks.
- elastic support stockings, including pressure gradient hose, up to a maximum of 20 pairs per person in a benefit year.
- custom-made orthotic inserts for shoes, when prescribed by a doctor, podiatrist or chiropodist, including the cost of x-rays and doctor's fees related to the orthotic.
- hearing aids prescribed by an ear, nose and throat specialist, up to a maximum of $350 per person over a period of 60 months. Repairs are included in this maximum.
- intraocular lens implants, contact lenses or first pair of eyeglasses after a cataract surgery, when prescribed by an ophthalmologist or licensed optometrist, up to a maximum of $200 per surgery.

- radiotherapy or coagulotherapy.
- oxygen, plasma and blood transfusions.
- glucometers prescribed by a diabetologist or a specialist in internal medicine, up to maximum of one monitor per person over a period of 4 benefit years.

Paramedical services

We will cover 100% of the costs, after you pay the deductible, up to the maximum indicated below for each category of paramedical specialists:

- licensed chiropractors up to a maximum of $400 per person in a benefit year and limited to a maximum of $25 per visit. We will also cover up to a maximum of $25 for x-ray examinations each benefit year.
- licensed osteopaths or osteopathic practitioners, up to a maximum of $180 per person in a benefit year. We will also cover up to a maximum of $25 for x-ray examinations each benefit year.
- licensed psychologists, up to a maximum of $50 per visit and limited to a maximum of $500 per person in a benefit year.
- licensed physiotherapists.

Payments after coverage ends

If the Extended Health Care benefit terminates, coverage for dental services to repair natural teeth damaged by an accidental blow will continue, if the accident occurred while you were covered, and the procedure is performed within 6 months after the date of the accident.

What is not covered

We will not pay for the costs of:

- services or supplies payable or available (regardless of any waiting list) under any government-sponsored plan or program, except as described below under *Integration with government programs*.
- services or supplies to the extent that their costs exceed the

reasonable and usual rates in the locality where the services or supplies are provided.

- equipment that Sun Life considers ineligible (examples of this equipment are orthopaedic mattresses, exercise equipment, air-conditioning or air-purifying equipment, whirlpools, humidifiers, and equipment used to treat seasonal affective disorders).
- any services or supplies that are not usually provided to treat an illness, including experimental treatments.
- services or supplies that are not approved by Health Canada or other government regulatory body for the general public.
- services or supplies that are not generally recognized by the Canadian medical profession as effective, appropriate and required in the treatment of an illness in accordance with Canadian medical standards.
- services or supplies that do not qualify as medical expenses under the Income Tax Act (Canada).
- services of an ophthalmologist or licensed optometrist.
- services or supplies for which no charge would have been made in the absence of this coverage.

We will not pay benefits when the claim is for an illness resulting from:

- the hostile action of any armed forces, insurrection or participation in a riot or civil commotion.
- any work for which you were compensated that was not done for the employer who is providing this plan.
- participation in a criminal offence.

Integration with government programs

This plan will integrate with benefits payable or available under the government-sponsored plan or program (the *government program*).

The covered expense under this plan is that portion of the expense that is not payable or available under the government program, regardless of:

- whether you have made an application to the government program,
- whether coverage under this plan affects your eligibility or entitlement to any benefits under the government program, or
- any waiting lists.

Government cutback

Extended Health Care coverage is provided in conjunction with government-sponsored plans or programs, and is based on the presumption that the services or supplies currently payable under these plans or programs will not be reduced or eliminated. If coverage of a service or supply under any government-sponsored plan or program is reduced or eliminated, the expenses which cease to be covered will not be automatically covered by this plan.

When and how to make a claim

To make a claim, complete the claim form that is available from Sun Life.

In order for you to receive benefits, we must receive the claim no later than 90 days after the earlier of:

- the end of the benefit year during which you incur the expenses, or
- the end of your Extended Health Care coverage.

Life Coverage

General description of the coverage

Your Life coverage provides a benefit for your beneficiary if you die while covered.

Life coverage for you

Amount

Your Life benefit is $7,500.

Who we will pay

If you die while covered, Sun Life will pay the full amount of your benefit to your last named beneficiary on file with Sun Life.

If you have not named a beneficiary, the benefit amount will be paid to your estate. Anyone can be your beneficiary. You can change your beneficiary at any time, unless a law prevents you from doing so or you indicate that the beneficiary is not to be changed.

A minor cannot personally receive a death benefit under the plan until reaching the age of majority. If you reside outside Québec and are designating a minor as your beneficiary, you may wish to designate someone to receive the death benefits during the time your beneficiary is a minor. If you reside outside Québec and have not designated a trustee, current legislation may require Sun Life to pay the death benefit to the court or to a guardian or public trustee. If you reside in Québec, the death benefit will be paid to the parent(s)/legal guardian of the minor on the minor's behalf. Alternatively, you may wish to designate the estate as beneficiary and provide a trustee with directions in your will. You are encouraged to consult a legal advisor.

Converting Life coverage

If your Life coverage ends or reduces for any reason other than your request, you may apply to convert the group Life coverage to an individual Life policy with Sun Life without providing proof of good health.

The request must be made within 31 days of the reduction or end of the Life coverage.

There are a number of rules and conditions in the group contract that apply to converting this coverage, including the maximum amount that can be converted. Please contact Sun Life for details.

When and how to make a claim

Claims for Life benefits must be made as soon as reasonably possible. Claim forms are available from Sun Life.

Respecting your privacy

At Sun Life Financial, protecting your privacy is a priority. We maintain a confidential file in our offices containing personal information about you and your contract(s) with us. Our files are kept for the purpose of providing you with investment and insurance products or services that will help you meet your lifetime financial objectives. Access to your personal information is restricted to those employees, representatives and third party service providers who are responsible for the administration, processing and servicing of your contract(s) with us, our reinsurers or any other person whom you authorize. In some instances these persons may be located outside Canada, and your personal information may be subject to the laws of those foreign jurisdictions. You are entitled to consult the information contained in our file and, if applicable, to have it corrected by sending a written request to us.

You have a choice

We will occasionally inform you of other financial products and services that we believe meet your changing needs. If you do not wish to receive these offers, let us know by calling 1-877-SUN-LIFE (1-877-786-5433).

To find out about our Privacy Policy, visit our website at *www.sunlife.ca*, or to obtain information about our privacy practices, send a written request by e-mail to *privacyofficer@sunlife.com*, or by mail to Privacy Officer, Sun Life Financial, 225 King St. West, Toronto, ON M5V 3C5.