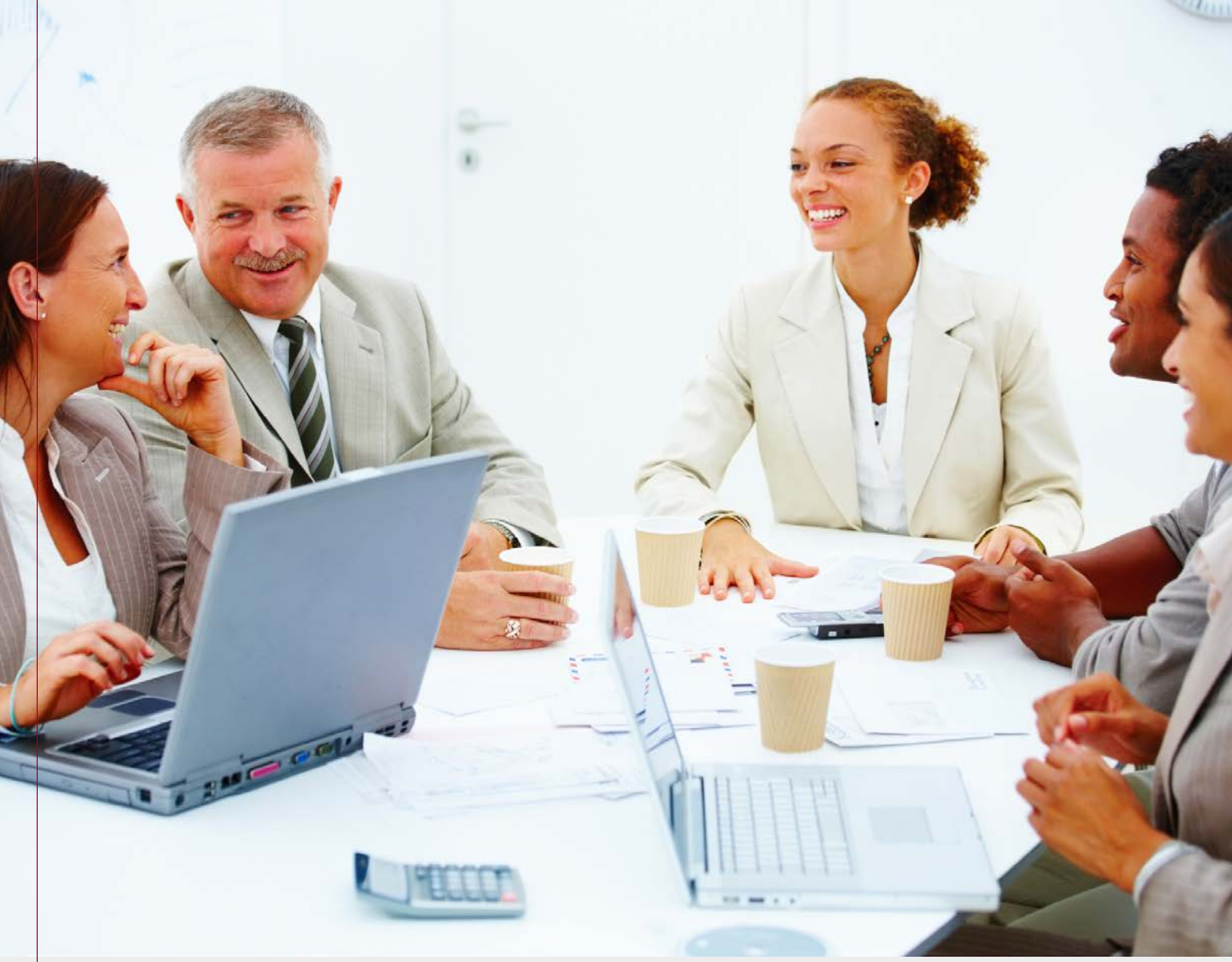

Selectpac

An administration guide for your Great-West Life group benefits plan

THE Great-West Life ASSURANCE COMPANY

CONTACTS

Selectpac Member Administration

Selectpac Member Administration
P.O. Box 6000
Winnipeg, MB, R3C 3A5
Fax: 204-946-8972

Premium payment

Group Insurance Payment Administration
P.O. Box 1053
Winnipeg, MB, R3C 2X4

Life and Accidental Death & Dismemberment Claims

Group Life Claims
P.O. Box 6000
Winnipeg, MB, R3C 3A5
Phone: 204-946-4096
Fax: 204-946-8783

Disability Claims (SK, all Atlantic, all Ontario except London)

Hamilton Disability Management Services Office
801 - 1 King St. West
Hamilton, ON, L8P 4X9
Toll-free: 1-800-330-2270
Phone: 905-317-2660
Fax: 905-317-2642

Disability Claims (Quebec and all French-speaking clients)

Montreal Disability Management Services Office
1140-2001 University Street
Montreal, PQ, H3A 1T9
Toll-free: 1-888-878-6059
Phone: 514-350-7900
Fax: 514-350-7925

Disability Claims (BC, AB, MB, YT, NWT, NU and London, ON)

London Disability Management Services Office
255 Dufferin Avenue
London, ON, N6A 4K1
Toll-free: 1-866-325-6413
Phone: 519-435-7229
Fax: 519-435-7000

Health, prescription drugs and dental inquiries (English Clients)

Health and Dental Benefit Payment Office
P.O. Box 3050
Winnipeg, MB, R3C 0E6
Plan administrator access line: 1-877-421-5032
Plan administrator email: h&dplanadmin@gwl.ca
Plan member inquiries: 1-800-957-9777

Health, prescription drugs and dental inquiries (French Clients)

Montreal Benefit Payments
Place Bonaventure
800 de la Gauchetière Street West, Suite 5800
Montreal PQ H5A 1B9
Plan administrator access line: 1-877-421-5032
Plan administrator email: h&dplanadmin@gwl.ca
Plan member inquiries: 1-800-957-9777

Healthcare Spending Account or *Health SolutionsPlus*

Plan administrator or plan member inquiries:
1-877-883-7072.

Out-of-Country

Out-of-Country Claims
P.O. Box 6000
Winnipeg, MB, R3C 3A5
Plan administrator access line: 1-877-421-5032
Plan member inquiries: 1-800-957-9777

GroupNet Helpline

Plan administrator access line: 1-800-665-2648
Plan member inquiries: 1-800-957-9777

Supply Services

Great-West Life Supply Department
P.O. Box 6000
Winnipeg, MB, R3C 3A5
Phone: 204-946-7760
Fax: 204-946-4137

Medical Reimbursement Plan

Plan administrator or plan member inquiries:
1-877-883-7072

INTRODUCTION

This *Administration Guide* is designed to simplify your role in the administration of your Great-West Life group benefits plan. You'll find step-by-step procedures you need to follow to ensure your plan runs as smoothly as possible.

While the guide reflects the administrative procedures of your plan, this information in no way modifies or replaces the provisions of your master policy. In determining the rights and obligations of both the plan sponsor and plan members, the provisions of your master policy apply.

Although we've done our best to describe your plan's administrative procedures as fully as possible, you may encounter situations that require further explanation. Should you require further assistance, your local Great-West service representative is always available to help.

This guide includes information about all available products, some of which may not be included with your plan. Please consult your contract for details of your plan's features, and contact your Great-West representative with any questions.

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Plan administrator role and responsibilities

Your company has entrusted you with the responsibility of administering your group plan. As the plan administrator and on behalf of your employer (the plan sponsor), you'll be responsible for the following tasks:

- Delivering coverage materials and information about the benefits plan to employees
- Being aware of and informing your employees of any enrollment deadlines and the consequences of not meeting the deadlines
- Letting employees know about any optional coverage available to them and the process of applying for coverage
- Establishing processes to monitor files and follow up on incomplete forms and submission of information
- Ensuring the proper amount of premium is collected and paid to Great-West prior to the premium due date
- Upon employee termination, informing the individual about the conversion privilege under life insurance and any other conversion rights or extended coverage that may be available to them

When in doubt about your responsibilities or how to perform them, contact your local Great-West service representative.

GroupNet online services

Great-West's *GroupNet* secure online services can help simplify plan administration and provide easy access to information for both you and your plan members.

If you're set up for ***GroupNet for Plan Administration***, you should use it to keep plan member records up to date and access your plan's billing information. If you're not already on *GroupNet for Plan Administration* and would like to get set up, contact your local Great-West service representative to help you get started.

Your plan members can access personalized benefits information, customized claim forms and more online with ***GroupNet for Plan Members***. Encouraging your plan members to use *GroupNet* can help you save time in answering questions about your plan.

To get plan members registered, point them to www.greatwestlife.com. Communication materials are available from your Great-West service representative to help promote sign-up.

Important plan administration tips: time-sensitive!

Enrollment deadline

Enrolling new employees and keeping their lifestyle changes up to date within the required time periods will ensure that they avoid late applicant status. You can avoid late applicant situations by:

- Enrolling all new participants prior to the end of their eligibility waiting period.
- Reminding employees that all major lifestyle status changes (e.g. adding a spouse, birth or adoption of a child, losing coverage under an insured spousal plan, etc.) must be submitted within 31 days of the event.

Adding employees

Here are a few things to consider when adding employees to your plan:

- Great-West must receive an *original* signed *Application for Group Coverage* form to process coverage for an employee (even if *GroupNet for Plan Administration* is in place and you've added the applicant online). The beneficiary nomination makes completion of this form a legal requirement.
- While new employees have the entire eligibility waiting period to apply for coverage, we recommend application forms be completed and sent to Selectpac Member Administration 2–3 weeks prior to the end of the employee's eligibility waiting period. Based on the coverage volumes requested, evidence of insurability may be required. Submitting forms early provides time to process these applications and request additional medical information that may be required. If a new employee's offer of employment includes immediate benefit coverage, you may waive the eligibility waiting period. If you don't use *GroupNet*, Great-West will require this request in writing. This request needs to indicate the employee's name and date of hire, and must be attached to the employee's *Application for Group Coverage* form.
- Provincial healthcare coverage is mandatory. If a new employee is not eligible for provincial coverage, please contact your local Great-West service representative.

Terminations and leaves of absence

When an employee is terminated, and subject to your contract provisions, all or part of the life insurance, disability insurance and optional life insurance may be converted to individual insurance. Health and dental insurance products are also available. If an employee is temporarily laid off or on leave of absence, insurance may be continued for the maximum periods specified in your contract, provided premium continues to be paid.

Common-law definition

A common-law spouse is considered eligible for coverage from the first day of cohabitation.

Evidence of insurability

Medical evidence and proof of insurability is required in any of the following situations:

- A new employee is eligible for excess insurance in an amount exceeding the non-evidence maximum (NEM).
- The first time the NEM is exceeded (regardless of the percentage of salary increase).
- For earnings increases of more than 10% over a one-year period.
- For employees who have been previously declined for excess insurance and now wish to increase their coverage.
- For employees over the age of 65 applying for increased amounts of excess life insurance.
- For employees who are considered late applicants.

Clients with long-term disability (LTD) coverage

Do not destroy the LTD contract with your prior carrier for at least one full year after this plan takes effect. Most Great-West plans contain a one-year pre-existing conditions clause for LTD; we may need to refer to your old contract if an employee is on disability within the first year of coverage with Great-West.

Deductibles

Deductibles are payable from January to December of each year (calendar-year basis).

Emergency travel insurance

Emergency out-of-country care provides out-of-country coverage up to 60 days per trip.

British Columbia Fair PharmaCare Program

The Government of British Columbia subsidizes eligible prescription drugs and designated medical supplies through the Fair PharmaCare program, and this assistance level is based on net family income. To ensure proper co-ordination of benefits between your Great-West drug plan and the provincial PharmaCare program, employees may need to provide Great-West with proof of PharmaCare registration. If necessary, the employee will receive a letter from Great-West requesting they register for PharmaCare. The employee can register online at www.healthservices.gov.bc.ca/pharme/index.html or by calling toll-free at 1-800-663-7100. Once the registration process has been completed, the employee should fax a copy of the PharmaCare confirmation statement to the PharmaCare Drug Services Unit at 1-204-946-7664. Failure to submit the PharmaCare confirmation to Great-West will result in temporary suspension of prescription drug claims.

Quebec Bill 130 – Mandatory drug coverage and private plan opt-out process

Quebec employees choosing to opt out of their private group health plan coverage must provide proof of alternate coverage under a spousal or association plan. If an employee fails to provide proof of alternate coverage, this plan is obligated to collect premiums from the employee for the drug-related portion of the health plan. Once employees become eligible for coverage under this plan, they are no longer eligible under the public plan and should immediately cancel their RAMQ coverage. Contact your local Great-West service representative for more details on how to opt out of this plan or the RAMQ plan.

ORDERING SUPPLIES

1. Complete the self-addressed *Supply Request Form*.
2. Include the form number(s) and quantities required. Clearly print your return address and policy number on the request form.
3. Mail or fax the form to Great-West Supply Services.

Allow approximately two weeks for delivery. If you need interim supplies, contact your local Great-West service representative.

Re-ordering benefits cards and employee benefit booklets

To re-order supplies for those items that include your organization's specific name and policy number, contact your local Great-West service representative.

FORMS

Most administration and claim forms referred to in this guide are available online at www.greatwestlife.com. Forms are always up to date and easy to download, and, for your convenience, direct links have been imbedded throughout this document that will take you directly to the forms you need. You'll require Adobe Acrobat Reader to view and print forms. Reader is available as a free download at http://www.adobe.com/products/acrobat/readstep2.html.

Below you'll find a list of common forms referred to throughout this guide.

Administration

Note: Administration Forms should be mailed to Selectpac Member Administration

- M6108 Application for Group Coverage
- M6108(GN) Application for Group Coverage – *GroupNet clients only*
- M6129 Evidence of Insurability
- M6109 Employee Change
- M6109(GN) Employee Change – *GroupNet clients only*
- M266(SEL) BIL Group Insurance Adjustments
- M6242 BIL Trustee Appointment
- M6320 BIL Consent to Change of Irrevocable Beneficiary
- M5725 Group Life Conversion Privilege Notification
- M5725(Quebec) Group Life Conversion Privilege Notification *(Quebec only)*
- M5995(CI) Critical Illness Evidence of Insurability
- M403 BIL Notice of Return to Work
- M6901 BIL Sonata Health & PlanDirect Comparison Brochure
- M173(D52) Supply Request Form
- 779E Premium Payment Envelope

Claims

- M635D Healthcare Expense Statement
- M7088 Request for Brand-Name Drug Coverage
- Prescription Drugs Prior Authorization
- M5432 (HO) Statement of Claim - Out-of-Country Expenses
- Provincial Out-of-Country Third-Party Agreement
- M445D BIL Standard Dental Claim Expense Statement
- M4307 Long-Term Disability Income Benefit – Employee's Statement
- M4306 Application for Group Long-Term Disability – Employer's Statement
- M5454 Short-Term Disability Income Benefits – Employee's Statement
- M5453 Application for Group Short-Term Disability Benefits – Employer's Statement
- M6734D Medical Reimbursement Plan
- M6537 Critical Illness Claimant's Statement
- Critical Illness Confidential Physician Report claim form

DEFINITIONS

Employee

An individual in the service of the employer on an active, permanent, full-time basis. The standard contract definition excludes employees who work less than 24 hours per week.

Spouse

The employee's legal spouse, common-law spouse or former spouse. A common-law spouse is eligible upon immediate co-habitation.

A former spouse means a divorced or ex-common-law spouse for whom insurance protection for some of the benefits available under the employer's benefit program is mandated by court order.

Dependent children

Unmarried children who are:

- Under 21 years of age
- Under 25 years of age and registered in full-time attendance at university or a similar institution
- Any age and incapable of supporting themselves due to a continuous physical or mental disorder that begins before the age of 21, or while they are students and under the age of 25

Note: In Quebec, dependent children are covered for drugs up to age 26.

The child must be chiefly dependent on the employee for support and maintenance. Children under age 21 are not covered if they are working more than 30 hours a week, unless they are full-time students.

Child includes any stepchild, adopted child or any other child for whom the employee or the insured spouse has been appointed legal guardian.

Dependant definition includes the offspring of an unmarried, natural, adopted or stepchild of the employee or the insured spouse, as long as the offspring is living with the employee and the employee is claiming the offspring as a dependant for income tax purposes.

Family status or lifestyle change

These include:

- Birth or adoption by the employee of a first child
- The employee's marriage (legal or common-law)
- Divorce or termination of a common-law relationship by the employee
- Death of an employee's spouse
- Death of the employee's only insurable child
- The employee's spouse losing benefits coverage elsewhere
- The employee no longer having any children eligible for dependant coverage

Average hours worked per week

Great-West uses an average of 40 hours per week to convert an employee's hourly rate of pay to annual earnings. Please notify your Great-West service representative if the number of hours is other than 40.

Earnings

The basic rate of pay excluding overtime, bonuses and commissions.

Non-evidence maximum

The amount of insurance for which an employee can be covered without approval of insurability by Great-West.

Excess insurance

The amount of Life or Disability insurance an employee is eligible for that exceeds the non-evidence maximum.

Eligibility waiting period

The period of time between the employee's initial date of employment and the date the employee becomes eligible for coverage through this plan.

Actively at work

Plan members who are not disabled and who are actually working, either at their plan sponsor's place of business or where they're required to work, are considered to be actively at work. Plan members absent due to vacation, weekends, statutory holidays or shift variances are considered actively at work.

Co-ordination of benefits (COB)

In some situations, an employee and his or her dependants may have similar benefit coverage under another group insurance plan. Your plan contains a COB provision designed to share the cost between plans and ensure the employee receives the maximum overall benefit. COB also ensures the employee is not reimbursed for more than the actual expenses incurred.

The order of claims submission is as follows:

1. The employee sends the claim to his or her own plan first.
    a. If the employee is covered as an active full-time or part-time employee under two plans, the plan with the earliest effective date is primary.
    b. A retiree plan will always pay second after any group plan that covers the same individual as an active full-time or part-time employee.
2. The spouse sends the claim to his or her plan first.
3. Claims for dependent children are sent to the plan of the parent who has the earlier birthday in the year. For example, if the employee's birthday is April 8, and the spouse's birthday is March 12, the claim must be sent to the spouse's plan first.
4. Any claims not paid in full by the first plan should be sent to the other plan together with a copy of the *Explanation of Benefits* and receipt.

ADDING NEW EMPLOYEES

All employees and their eligible dependants must participate in this plan upon completion of the eligibility waiting period.

Steps to adding a new employee

1. Provide the employee with an *Application for Group Coverage* form.
2. Have the employee complete all sections of the *Application for Group Coverage* form in ink, except those marked **To be completed by the Plan Administrator**, with the employee returning the form to you.
3. Review the form to ensure it's fully completed, legible, signed and dated by the employee.
4. Complete the **To be Completed by the Plan Administrator** section of the form.
5. Mail the original *Application for Group Coverage* form to Selectpac Member Administration and keep a copy of the form for your records.

If you have access to *GroupNet's* enrollment feature, you can add a new employee online using the information from the completed *Application for Group Coverage* form. From the *GroupNet for Plan Administration* home page at www.greatwestlife.com, simply click enrollment and follow the on-screen instructions to add a new person. Once you've added the employee on *GroupNet*, mail the original *Application for Group Coverage* form to Selectpac Member Administration, as we may require the original for beneficiary designation purposes.

Importance of applying for coverage within 31 days of becoming eligible

Employees must complete and sign the *Application for Group Coverage* form within 31 days of becoming eligible for coverage. Note that if the application is signed after the eligibility date but within the 31-day grace period, the effective date of coverage will be the date the application was signed. We'll consider any employee who applies after this 31-day period a late applicant.

Coverage effective date

Coverage becomes effective on the day the employee has satisfied the waiting period as specified in your master policy (usually three months), if the employee is actively at work on that day.

Conditions for waiving benefits

Health and dental benefits may be waived only if the employee and/or his or her eligible dependants are covered by a spousal plan. Spousal information must be noted on the *Application for Group Coverage* form.

Waiving the waiting period

If a new employee's offer of employment includes immediate benefit coverage, you may waive the eligibility waiting period. If you do not have the *GroupNet* enrollment feature, a letter requesting the waiver, and including the employee's name and date of hire, must be attached to the employee's *Application for Group Coverage* form.

New employee welcome package

Once you've added a new employee, please provide them with the items listed below so they can start enjoying the advantages of your company's benefits plan. Subject to plan design, each new employee should receive the following:

1. Welcome package email
2. Employee booklet
3. Benefit statement
4. Benefits card
5. Health SolutionsPlus Visa® payment card

At inception, we'll provide you with an electronic employee welcome package along with extra employee booklets (if requested, otherwise electronic) and GMA cards. If your supply runs low on these materials, please contact your local Great-West service representative. All other materials listed above contain information specific to each employee and as such will be customized and mailed directly to you for distribution.

Late applicants

New employees and/or current insured employees with family status or lifestyle changes must apply for coverage within 31 days of being eligible. Otherwise, they are considered late applicants. All late applicants must submit medical evidence before coverage can be considered.

To submit medical evidence:

1. Complete the **To be completed by the Plan Administrator** sections of both the *Application for Group Coverage* form and the *Evidence of Insurability* form for the employee who is applying as a late applicant.
2. Provide the employee with the two forms, along with an envelope.
3. For family coverage, the employee should complete both the **employee** and the **spouse and children** questions. Both the employee and the spouse must sign the *Evidence of Insurability* form to obtain family coverage.
4. The employee is to keep a copy of the completed *Evidence of Insurability* form.
5. Have the employee return the original *Evidence of Insurability* form to you in the sealed envelope, along with the *Application for Group Coverage* form. Send both forms to Selectpac Member Administration.
6. Great-West may ask for more information while reviewing the application with all associated expenses being incurred by the plan member. We'll let you know in writing if the application has been approved or declined. If approved, the coverage will be effective on the date of approval.
7. We'll add the new employee for you, even if you have *GroupNet*. No further action is required on your part.

Restricted dentalcare benefits

When an employee is approved as a late applicant, and for plans that include dentalcare, benefits will be subject to certain initial coverage restrictions:

- Routine (Basic) Treatment expenses are limited to a maximum of $100 during the first 12 months.
- No benefits will be paid for Major Treatment expenses during the first 12 months.
- No benefits will be paid for Orthodontic Treatment expenses during the first 24 months.

These limitations do not apply to expenses that are solely the result of an accident that occurred after the employee's dentalcare insurance took effect.

Refer to your master policy for further details.

BENEFICIARY DESIGNATIONS

All employees are required to properly and adequately designate a beneficiary on their application form.

New employee designating a beneficiary

Ensure the employee completes the beneficiary designation section on the *Application for Group Coverage* form. The employee must provide full given names, surnames and the relationship to the employee for all designated beneficiaries.

Crossed out designation

If the employee crosses out or uses correction tape on any portion of the designation, he or she must initial the change.

Minor children

If the beneficiary is a minor child, a trustee designation is recommended. The employee may wish to appoint a trustee by completing the *Trustee Appointment Form*.

Québec residents

If the employee resides in Québec and designates his or her spouse as beneficiary, the spousal beneficiary is irrevocable unless the employee makes the designation revocable. All other designations (other than the spouse) made on or after this date are revocable unless stated otherwise.

Divorce automatically cancels the irrevocable beneficiary designation. In this situation, an employee can make a change of beneficiary without any written consent from the previous irrevocable beneficiary.

Changing a beneficiary

To make a beneficiary designation change, the employee must complete the change of beneficiary section of the *Employee Change* form. Make sure the *Employee Change* form is signed and dated by the employee. Once complete, send the form to Selectpac Member Administration. Retain copies of the completed forms for your records.

Changing an irrevocable beneficiary

An employee cannot change an irrevocable beneficiary without the written consent of the irrevocable beneficiary. If the employee wants to change the irrevocable beneficiary, he or she must have the irrevocable beneficiary complete the *Consent to Change of Irrevocable Beneficiary* form, available online at www.greatwestlife.com. If the employee has named a minor child as the irrevocable beneficiary, the child cannot give valid consent to the change until he or she reaches the age of majority.

Once the employee has collected the *Consent to Change of Irrevocable Beneficiary* form from the irrevocable beneficiary, this form, along with the *Employee Change* form, is sent to Selectpac Member Administration.

Revocable beneficiary

An employee can change a revocable beneficiary at any time without the written consent of the revocable beneficiary.

To change a revocable beneficiary, complete the *Employee Change form* and send it to Selectpac Member Administration.

Beneficiary designation examples

To avoid legal complications that may result from an unclear or vague designation, here are sample designations that are considered satisfactory and will usually present no problem in the payment of claims:

One beneficiary:	Martin, Marie (Spouse) or Girard, Robert (Friend)
Estate:	"Estate" or "My Estate" or, in the province of Quebec, "Legal Heirs"
Contingent beneficiary:	Martin, Marie (Spouse) if living otherwise Martin, Julie (Daughter)
Two beneficiaries*:	Martin, Marie (Spouse), Martin, Julie (Daughter)
Multiple beneficiaries*:	Martin, Marie (Spouse), Martin, Charles (Son), Martin, Julie (Daughter)

* Unless otherwise instructed by the employee, monies will be distributed equally to the surviving beneficiaries.

EXCESS INSURANCE

Medical evidence and proof of insurability is required in any of the following situations:

- A new employee is eligible for excess insurance and the amount for which he or she is eligible exceeds the non-evidence maximum (NEM).
- the first time the NEM is exceeded (regardless of the percent of salary increase).
- for earnings increases of more than 10% over a one-year period.
- for employees who have been previously declined for excess insurance and now wish to increase their coverage.
- for employees over the age of 65 applying for increased amounts of excess life insurance.
- for employees who are considered late applicants.

Once provided, evidence is valid for six months from the date of signature. While the premium rate itself will not change, the total amount of premium paid by the employee will increase due to the increase in his or her benefit level.

Prior to a new employee applying for excess insurance, you should provide them with an excess insurance letter. This letter can be customized to outline the available coverage amounts for every employee under your plan for the life, AD&D, short-term and long-term disability benefits. The letter also includes a declination statement from the employee, should they decline to exercise their right to apply for excess coverage. We recommend you keep this signed letter on file so your company can refer to it at a later date if required.

Application process

1. Complete the **To be completed by the Plan Administrator** sections of the *Evidence of Insurability* form for the employee who is applying for excess coverage.
2. Provide the employee with the *Evidence of Insurability* form along with an envelope.
3. The employee completes the **Medical and Lifestyles Questionnaire** portion of the form and retains a copy for their records.
4. The employee returns the original *Evidence of Insurability* form to you in the sealed envelope. Send the sealed envelope to Selectpac Member Administration.
5. Great-West may ask for more information while reviewing the application. We'll let you know in writing if the application has been approved or declined. If approved, the coverage will be effective on the date of approval.
6. We'll add the new employee for you, even if you have *GroupNet*. No further action is required on your part.

Note: If an employee is declined for excess insurance and the non-evidence maximum is increased at a later date, that employee will be eligible for increased coverage up to the new NEM.

EMPLOYEE CHANGES

If you have access to *GroupNet's* enrollment feature, you can make employee changes and revisions online without the need to complete and submit most paper forms. From the *GroupNet for Plan Administration* home page at www.greatwestlife.com, simply click enrollment and follow the on-screen instructions.

Increases in insurance coverage apply only if an employee is actively at work. Otherwise, the change will not become effective until the employee returns to work. Decreases in coverage take effect as they occur.

Employee changes include any adjustments in coverage due to a salary change. A salary increase that takes place while an employee is not actively at work should not be reported until a disability is over to avoid an overcharge in premium. A salary decrease while an employee is not actively at work should be reported immediately.

Should there be a claim while an employee is not actively at work, the benefit will be based on the plan member's reported salary as of the last day worked.

Earnings

Complete the *Group Insurance Adjustments* form, and send the revised earnings information to Selectpac Member Administration.

Family status (single/family)

Employees must complete and sign the *Employee Change* form within 31 days of the date of the change. We'll consider the employee's dependants to be late applicants if they apply after this 31-day period.

Send the completed form to Selectpac Member Administration.

Division, class, province of residence and province of employment

Complete the *Group Insurance Adjustments Form*, and send the completed form to Selectpac Member Administration.

Employee name, dependants and waiver of health and dental benefits

Have the employee complete and sign the *Employee Change* form and send the form to Selectpac Member Administration.

If an employee loses coverage under his or her spouse's plan, the employee can be covered for the benefits which he or she was previously entitled to but waived, provided the request for coverage is made within 31 days of the spousal coverage termination date. Should an employee request coverage after this 31-day period, he or she will be considered a late applicant.

TERMINATION AND LEAVE OF ABSENCE HANDLING

If you have access to *GroupNet's* enrollment feature, you can terminate an employee without the need to complete and submit most paper forms. From the *GroupNet* for Plan Administration home page at www.greatwestlife.com, simply click enrollment and follow the on-screen instructions.

If you do not have access to *GroupNet*, for all terminations and leaves of absence, complete the *Group Insurance Adjustments* form and send it to Selectpac Member Administration.

Termination dates are calculated using the first day of no coverage. Therefore, when the last day of employment is used, the system will calculate the date of termination as the following day. For example, if an employee's last day of work is Dec. 15, the first day without coverage is Dec. 16.

A terminated employee may continue to have insurance needs once they leave your company. To assist with this transition, provide the employee with a departure letter (see appendix for letter template) and *Sonata Health* and *PlanDirect* comparison brochure (available online at www.greatwestlife.com or by completing a supply request card and sending it to Supply Services).

Conversions

When an employee or spouse's group life or long-term disability (LTD) insurance coverage is reduced or terminated, he or she may be entitled to convert all or part of his or her coverage to an individual insurance policy without providing medical evidence of insurability.

For assistance in handling conversion requests, employees and their spouses will be required to consult with a financial security advisor. This will ensure the departing employee or spouse receives the professional advice required to make informed decisions when applying for individual insurance.

Life conversions

1. When an employee's or spouse's group life insurance coverage is reduced or terminated, complete the *Group Life Conversion Privilege Notification* form. In most situations, your current agent of record will be your plan's financial security advisor conversion contact. If your agent of record is not able to act as the conversion contact, leave the *Financial Security Advisor Information* section blank. Refer to your group policy to complete the *Group Life Insurance Information* section.
2. When complete, provide one copy of the form to the employee/spouse and keep one copy for your files.

Completed applications for individual insurance and the first premium must be received by Great-West within 31 days of the group insurance being terminated or reduced (the conversion period). During the conversion period, the group life coverage in effect prior to the date of termination or reduction will be extended.

LTD conversions

To be eligible, the employee must begin new employment within six months of terminating coverage under this plan. The employee must submit an application within 31 days of starting the new job. Conversion provisions and requirements (if applicable) are included in the employee booklet and the master policy.

Handling for life waiver of premium claims for plan members under age 65

1. Claim is approved: the plan member's life insurance will continue premium-free until age 65, providing the definition of disability continues to be met
2. Claim is declined: if the claim is declined, the plan member's life insurance can continue with premium payment until age 65.
3. No application: if the plan member does not apply for life waiver of premium, life insurance can continue with premium payment until age 65.

Handling for life insurance continuance for plan members age 65+

Life waiver of premium terminates at age 65, so there is no life waiver claim application necessary.

If you have Short-Term Disability (STD) with Great-West Life, or if you have Early Referral Services: Life insurance coverage can continue with premium payments, until the end of the STD benefit period, regardless of whether the plan member applies for STD.

Selectpac Member Administration will set future termination dates for the life insurance coverage on our system. In the event the plan member returns to work, please ensure the DMSO receives the appropriate notification so our system can be updated to reflect that the plan member has returned to work.

If you don't have STD with Great-West Life, life insurance coverage can continue with premium payments, until the end of the 6th month after the date the plan member was actively at work. It's your responsibility to stop premium payments after six months.

Important: Continuance of life coverage for plan members age 65+ must be administered the same for all plan members in like circumstances. If you do not want life insurance coverage continued on a premium-paying basis for your plan members, you must complete an adjustment form and forward to Selectpac Member Administration.

Coverage during layoff, leave of absence, illness or injury

If an employee departs on a temporary leave of absence or layoff, a scheduled return-to-work date is required. When this occurs, complete a *Group Insurance Adjustments* form and send to Selectpac Member Administration. The actual period of time during which coverage may be continued varies by benefit and termination reason. If an employee is temporarily laid off or on leave of absence, insurance may be continued for the maximum periods specified in your contract, provided premium continues to be paid.

Maternity/paternity leave

The following table provides a summary of maternity/parental leave requirements and Great-West administrative procedures.

Jurisdiction & Legislation	Type of Leave and maximum leave entitlement	Employee/Employer Choices offered by Great-West regarding benefit continuation
FEDERAL Canada Labour Code, RSC 1985, c L-2	• Qualifying period is 6 months. • Maternity leave is 17 weeks. • Maximum parental leave entitlement is 37 weeks; or 35 weeks if maternity leave is also taken. • Adoption leave is 37 weeks.	The **employee** must either continue all or opt out of all benefits coverage. If employee chooses to continue all, the employer must continue all benefits coverage that are currently employer paid.
ALBERTA Employment Standards Code, RSA 2000, c E-9	• Qualifying period is 52 weeks. • Maternity leave is 15 weeks. • Parental leave is 37 weeks. • Adoption leave is 37 weeks.	The **employer** can choose to continue all benefits coverage, or all except disability, or none. The employee must follow the employer's choice.
BRITISH COLUMBIA Employment Standards Act, RSBC 1996, c 113	• No qualifying period. • Pregnancy leave is 17 weeks. • Maximum parental leave is 37 weeks; 35 weeks if pregnancy leave is also taken. • Adoption leave is 37 weeks.	The **employee** must continue or opt out of all benefits coverage. If the employee chooses to continue all benefits coverage, the employer must continue all benefits coverage. The current premium contribution arrangement continues. If the employee chooses not to continue premium contributions, it remains the employer's choice if it wants to continue premium contributions for benefit coverage for that employee. The **employer** must continue to make payments for benefits coverage that are 100% employer paid.
MANITOBA The Employment Standards Code, CCSM c E110	• Qualifying period is 7 months. • Maternity leave is 17 weeks. • Maximum parental leave is 37 weeks. • Adoption leave is 37 weeks.	The **employer** can choose to continue all benefits coverage, or all except disability, or none. The employee must follow the employer's choice.
NEW BRUNSWICK Employment Standards Act, SNB 1982, c E-7.2	• No qualifying period. • Maternity leave is 17 weeks. • Maximum child care leave, which includes leave for adoption, is 37 weeks; 35 weeks if maternity leave is also taken.	The **employer** can choose to continue all benefits coverage, or all except disability, or none. The employee must follow the employer's choice.
NEWFOUNDLAND AND LABRADOR	• Qualifying period: 20 weeks. • Pregnancy leave 17 weeks. • Adoption leave 17 weeks. • Parental leave 35 weeks.	The **employer** can choose to continue all benefits coverage, or all except disability, or none. The employee must follow the employer's choice.
NORTHWEST TERRITORIES Employment Standards Act, SNWT 2007, c 13	• Pregnancy leave is 17 weeks. • Maximum parental leave entitlement is 37 weeks; 35 weeks if pregnancy leave is also taken. • Adoption leave is 37 weeks.	The **employee** must continue or opt out of all benefits coverage. If the employee chooses to continue all benefits coverage, the current premium contribution arrangement continues.

Jurisdiction & Legislation	Type of Leave and maximum leave entitlement	Employee/Employer Choices offered by Great-West regarding benefit continuation
NOVA SCOTIA Labour Standards Code, RSNS 1989, c 246	• Qualifying period is 1 year. • Pregnancy leave is 17 weeks. • Maximum parental leave is 52 weeks; 35weeks if pregnancy leave is also taken. • Adoption leave is 52 weeks.	The **employee** must continue or opt out of all benefits coverage. If the employee chooses to continue all benefits coverage, the current premium contribution arrangement continues.
NUNAVUT Labour Standards Act, RSNWT (Nu) 1988, c L-1	• Qualifying period is 12 months. • Pregnancy leave is 17 weeks. • Maximum parental leave is 37 weeks; 35 weeks if pregnancy leave is also taken. • Adoption leave is 37 weeks.	The **employee** must either continue all benefits or opt out of all benefits. Current premium contribution arrangement continues.
ONTARIO Employment Standards Act, RSO 1990, c E.14	• Qualifying period: 13 weeks. • Pregnancy leave is 17 weeks. • Maximum parental leave is 37 weeks, 35 weeks if pregnancy leave is also taken. • Adoption leave is 37 weeks.	The **employee** must continue or opt out of all benefits coverage. If the employee chooses to continue all benefits coverage, the current premium contribution arrangement continues. If the employee chooses not to continue premium contributions, it remains the employer's choice if it wants to continue premium contributions for benefit coverage for that employee. The **employer** must continue to make premium contributions for benefits coverage that is 100% employer paid.
PRINCE EDWARD ISLAND Employment Standards Act, RSPEI 1988, c E-6.2	• Qualifying period is 20 weeks. • Maternity leave is 17 weeks. • Parental leave 35 weeks, 35weeks if pregnancy leave is also taken. • Adoption leave is 52 weeks.	An **employee** can choose to continue all benefits (except disability) or opt out of coverage. If benefits are continued, the employee is responsible for the premiums. The **employer** can choose to pay for a portion of the premiums.
QUEBEC An Act Respecting Labour Standards, CQLR c N-1.1	• No qualifying period. • Maternity leave is 18 weeks. • Paternity leave (father) is 5 weeks. • Parental leave is 52 weeks. • Adoption leave is 52 weeks.	If the **employee** does not have access to a plan for private drug insurance through their spouse they must continue to participate in the benefit plan offered by their employer during the leave. If the employee has waived their insurance because they are covered through their spouses plan, they can choose to either maintain the coverage with their employer or terminate the coverage with their employer during the leave. Current premium contribution arrangement continues.
SASKATCHEWAN The Labour Standards Act, RSS 1978, c L-1	• Qualifying period is 20 weeks. • Maternity leave/adoption leave is 18 weeks. • Maximum parental leave is 37 weeks; 34 weeks if maternity or adoption leave is also taken	An **employee** can choose to continue all benefits or opt out of coverage. If benefits are continued, the employee is responsible for the premiums. The **employer** can choose to pay for a portion of the premiums.

Jurisdiction & Legislation	Type of Leave and maximum leave entitlement	Employee/Employer Choices offered by Great-West regarding benefit continuation
YUKON Employment Standards Act, RSY 2002, c 72	• Qualifying period is 12 months. • Maternity leave is 17 weeks. • Maximum parental leave is 37 weeks. • Adoption leave is 37 weeks	The **employee** must continue or opt out of all benefits coverage. Current premium contribution arrangement continues.

Chart last updated March 21, 2014. This guideline contains general information only and is not legal advice. The content of this guideline is based on information available at the time of its publication and is subject to change. Efforts have been made to ensure the accuracy of the information contained in this guideline; however, it may contain errors or omissions or become out of date following its publication. There may be factors, such as your health, occupation, or job seniority, which affect your entitlement to benefits during maternity, parental or adoption leave. We encourage you to review with your plan administrator their and your obligations, choices and handling during maternity, parental or adoption leave. For the purposes of this guideline, maternity and pregnancy leave are used interchangeably.

Severance

Benefits should be extended in accordance with provincial employment standards requirements.

For any extension of coverage (whether beyond the provincial employment standards requirements or not), approval is required. Contact your local Great-West service representative for assistance.

Note: Disability coverage, Optional Life and Optional AD&D coverage may not be extended beyond provincial employment standards requirements.

Reinstatement

If the employee was terminated due to illness, leave of absence or layoff, the employee may be reinstated immediately without having to comply with the eligibility waiting period, provided he or she returns to work within three months of his or her termination date. Otherwise, the employee is considered a new employee and should apply no later than 31 days following the return-to-work date in order to avoid late applicant status.

To reinstate an employee, complete the reinstatement section of the *Employee Change* form, along with the *Group Insurance Adjustments* form and send to Selectpac Member Administration.

ELECTRONIC CLAIM SERVICES

Your plan members may choose from a variety of methods to submit claims. Here is a quick look at some of the electronic options for claim submission.

Provider eClaims – With Great-West's *Provider eClaims* service, your plan members can have their claims submitted to Great-West when they visit approved providers, such as chiropractors, physiotherapists and visioncare providers. Claims are assessed automatically while the plan member waits. Refer to the *Client Services* section of www.greatwestlife.com for a current list of approved providers.

Member eClaims – This service allows online claim submission for a variety of covered services, including prescription drugs, dentalcare, visioncare, paramedical services, healthcare spending accounts and *Health SolutionsPlus,* depending on your group's plan design. Only claims incurred in Canada are eligible to be submitted through *Member eClaims*.

To use *Member eClaims*, plan members must be registered for *GroupNet for Plan Members*, and signed up for Direct Deposit of claim payments and eDetails for email notification when their claims are adjudicated. Plan members can also sign up to receive text messages on their mobile phone when their claims have been processed.

GroupNet Mobile – Great-West's free mobile app lets plan members use their Android™ device, BlackBerry®, iPhone® or iPod touch® to submit claims online with *Member eClaims* and access personalized coverage information. A short video that demonstrates Great-West's *GroupNet Mobile* app can be found at www.greatwestlife.com.

HEALTHCARE CLAIMS (INCLUDING VISIONCARE)

Claim submission

To process an eClaim, plan members must sign up on the *GroupNet for Plan Members* site at www.greatwestlife.com and provide the necessary information for direct deposit. Plan members can also sign up to receive text messages on their mobile device when their claims have been processed.

Receipts associated with eClaims must be kept for up to 12 months, since auditing may occur.

To process a paper claim:

1. The plan member completes the *Healthcare Expense Statement* form. For assistance completing a claim form, or for printable forms pre-filled with the plan member's name, plan information and claim centre mailing address, direct plan members to the *GroupNet for Plan Members* site at www.greatwestlife.com.
2. The plan member sends the completed *Healthcare Expense Statement* form to the Health and Dental Benefit Payment Office listed on the form, along with the original receipt(s).
3. We'll process the claim and send any eligible payments and an *Explanation of Benefits* (EOB) directly to the plan member at the address he or she provided on the claim form.

Plan members should keep a copy of the claim form and receipt(s) for future reference.

All claims must be submitted within 15 months of the date the expense is incurred.

Note: For hospital claims, the hospital generally sends the claim directly to Great-West. Great-West then reimburses the hospital and sends the employee an EOB. If a claimant is billed directly by the hospital, the above claim submission procedure should be followed.

Out-of-country claim submission

The employee should complete the *Out-of-Country Statement of Claim* and *Provincial Third-Party Agreement* forms and submit them along with original receipts to Out-of-Country Claims. A number of provinces also require an additional application for reimbursement form to be completed as well.

To gain access to the claim forms specific to your province of residence, visit www.greatwestlife.com, call the Out-of-Country Claims office or contact your local Great-West service representative.

Once we've received the completed forms, we'll submit the claim to the appropriate provincial plan for reimbursement on behalf of the insured employee. This allows Great-West to process the claim in a more timely fashion, compared to waiting for provincial reimbursement.

The claim will be processed, and any eligible payments and/or an explanation of benefits will be sent directly to the employee at the address indicated on the claim form.

Notes:

1. In a number of instances, provincial plans may require plan members to submit their claims and documents sooner than the claims submission period in your Great-West contract.
2. Each provincial plan has very specific time periods within which all claim documents must be submitted following the first date of medical treatment. For further details regarding out-of-country provincial plan claim requirements, visit www.greatwestlife.com.

Co-ordination of benefits

The co-ordination of benefits provision applies to all healthcare claims.

Claim inquiries

Claim inquiries should be directed to the Health and Dental Benefit Payment Office. To ensure a prompt response, the claimant must provide all of the following:

- The policy number
- The employee's name and identification number
- The patient's name
- The type of claim
- The date of service
- Any other particulars relating to the claim

Prior authorization of drug claims

Certain prescription drug claims need to be approved before Great-West can consider reimbursement. If your group benefits plan covers one of these drugs and an employee wants to be considered for coverage, advise the employee to:

1. Visit www.greatwestlife.com.
2. Select and print the appropriate *Request for Information* form, according to drug name.
3. Have the plan member's attending physician complete the form.
4. Send the completed form to the address indicated on the bottom of the *Request for Information* form.

PRESCRIPTION DRUG CARD BENEFITS

Great-West makes prescription drug card benefits available through its pharmacy benefit manager. Great-West handles administration, eligibility information and claims inquiries for you and all other covered plan members.

Our pharmacy benefit manager provides a network that receives, adjudicates and pays prescription drug card claims. It accepts electronic claims directly from pharmacies.

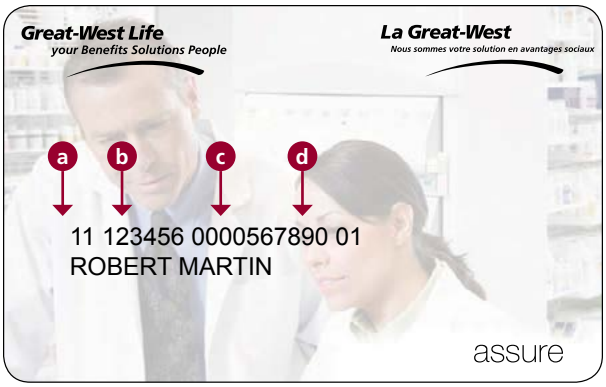
The card contains the following information necessary for processing a drug claim:

a. The first two digits identify Great-West as the carrier.

b. The next six digits identify your group policy number.

c. The next 10 digits make up the employee's identification number.

d. The final two digits identify the current issue number of the card. The issue number changes each time an employee's card is replaced, for instance, if it is lost or stolen. Once a card is replaced, the previous card becomes inoperative.



Claims procedure

1. The plan member presents his or her prescription drug card to the pharmacist each time a prescription drug is purchased.
2. The plan member pays deductibles, co-insurance and any other out-of-pocket amounts resulting from the plan design at the time of purchase.
3. If the plan member wishes to purchase a brand name drug instead of the generic* equivalent (where available), he or she will also be required to pay the difference between the cost of the generic equivalent and the brand name drug. If the plan member has a medical requirement for the brand name drug, he or she can apply for full coverage of that drug using the *Request for Brand Name Drug Coverage* form which is available at www.greatwestlife.com.

* Your plan includes generic substitution, which means the reimbursement amount of the prescription is limited to the cost of the lowest-priced generic alternative. Many drugs are available in both generic and brand name forms. Generic forms are typically less expensive but are just as effective as brand name forms. Both drugs have the same active chemical ingredient, same dosage strength, and same dosage form.

To replace lost or stolen cards, contact your local Great-West service representative.

Co-ordination of benefits

The co-ordination of benefits provision applies to all prescription drug card claims.

In situations where both spouses have drug card plans, pharmacists can use the electronic network to send the full amount of the claim to the primary plan and submit the claim for the outstanding balance to the secondary plan. In most cases, the plan member will complete the claim transactions at the pharmacy and will not have to file paper claims or wait for a reimbursement cheque.

Rejection of claim at a pharmacy

If the claim is rejected at the pharmacy, the plan member should ask the pharmacist to confirm correct entry of the date of birth and relationship code. If this information is correct, the pharmacist should contact the pharmacy benefit manager directly.

Paper-based claim submission

If a plan member does not present his or her drug card to the pharmacist when purchasing a drug, or the plan member is sending a claim for co-ordination of benefits, the plan member should complete a *Healthcare Expense Statement* form and send it along with the original pharmacy receipt(s) to the Health and Dental Benefit Payment Office.

Great-West will mail the reimbursement cheque directly to the plan member at the address provided on the claim form.

Claim inquiries

Claim inquiries should be directed to the Health and Dental Benefit Payment Office. To ensure a prompt response, the claimant must provide all of the following:

- The policy number
- The employee's name and identification number
- The patient's name
- The type of claim
- The date of service
- Any other particulars relating to the claim

Deferred prescription drug card claims procedure

1. The plan member presents his or her prescription drug card to the pharmacist each time a prescription drug is purchased.
2. The plan member is required to pay the claim in full at time of purchase. No claim form is required.
3. The pharmacy benefits manager will send a reimbursement cheque to the plan member's home address (or deposit reimbursement directly into the employee's bank account) the earlier of:
    a. The claims total for the plan member's family reaches the amount specified in your contract (e.g. $50 or $75), or
    b. The deferral period specified in your contract is reached (e.g. 30 or 90 days)

DENTALCARE CLAIMS

Claim submission

1. The dentist completes Part 1 of the Dentalcare Expense Statement.
2. The plan member completes Part 2 (Employee Information) and Part 3 (Coordination of Benefits). For assistance with a claim form, or for printable forms pre-filled with the plan member's name, plan information and claim centre mailing address, please direct plan members to the *GroupNet for Plan Members* website at www.greatwestlife.com.
3. The plan member sends the form to the Health and Dental Benefit Payment Office listed on the form, along with the original receipt(s).
4. We'll process the claim and send any eligible payments and an explanation of benefits directly to the plan member at the address indicated on the claim form.

Plan members should be encouraged to keep a copy of the claim form and receipt for future reference.

All claims must be submitted within 15 months of the date the expense is incurred.

Most dental offices have electronic claim submission capabilities which means the dentist is able to submit the claim electronically to Great-West for processing without the plan member having to send in any forms or receipts.

Assignment of payments

If the plan member would like Great-West to reimburse the dentist directly, the plan member must sign the assignment authorization sections of the *Dentalcare Expense Statement*. When an assignment is authorized for a particular claim, the assignment is irrevocable.

Treatment plan

For large Dentalcare claims (e.g. those exceeding $200), including all orthodontic claims, the plan member should send a treatment plan including X-rays to Great-West for consideration prior to receiving treatment. The claim form should clearly indicate this is a treatment plan and not an actual claim.

We'll provide the plan member and dentist with a written estimate of the amount payable by the plan. Original X-rays submitted will be returned to the dentist.

Co-ordination of benefits

The co-ordination of benefits provision applies to all dental claims.

Claim inquiries

Claim inquiries should be directed to the Health and Dental Benefit Payment Office. To ensure a prompt response, the claimant must provide all of the following:

- The policy number
- The employee's name and identification number
- The patient's name
- The type of claim
- The date of service
- Any other particulars relating to the claim

SURVIVOR BENEFITS

Dependant eligibility

If dependant coverage is in effect when an employee dies, the surviving dependant(s) will continue to receive coverage until the earliest of:

- 24 months from the employee's death
- The date when the survivor no longer qualifies as an insurable dependant (an employee's child born after the employee's death is considered an insurable dependant)

If your Great-West plan includes life insurance, contact your service representative when an insured employee dies for assistance in submitting the Life claim and Survivor Benefits claim.

If life insurance is not covered under this plan, provide Selectpac Member Administration with the date of the employee's death as you would normally provide any other employee changes. This will ensure benefits are transferred at the appropriate date and that benefit cheques are issued to the surviving spouse. If there is no surviving spouse, benefits are paid to the child of majority age or, in the case of a minor, to the child's legal guardian.

Coverage and premium

Coverage may be provided even if your group plan terminates after the employee's death. For a set period of time as outlined in your contract, premium will not be required for the surviving dependant(s) after the employee dies. Survivor Benefit coverage is intended to provide surviving dependant(s) with the same coverage they would have received if the employee was still living. Survivor Benefit coverage may be subject to the same changes as the rest of the group plan, should it be amended after the employee's death.

LIFE OR ACCIDENTAL DEATH & DISMEMBERMENT CLAIMS

Claim submission

For assistance with obtaining and completing claim forms, contact your local Great-West service representative or financial advisor (the agent of record on your group insurance plan).

LONG-TERM DISABILITY (LTD)

Online claim submission

Employees may apply for disability income benefits online. To start the online process, employees should go to www.greatwestlife.com – Client Services – Forms for Group Benefits Plan Members – Standard claim forms – Apply for Disability Income Benefits.

Paper claim submission

1. Provide the employee with a *Long-Term Disability Income Benefits - Employee's Guide*, with both the employee and physician completing the appropriate sections. The employee has the option of sending the statement directly to the Disability Management Services Office (DMSO) or they can return the statement to you in a sealed envelope.
2. Complete the *Application for Group Long-Term Disability – Employer's Statement*.
3. Send the employee and employer statements to the DMSO.
4. The DMSO will process the claim and advise you and the claimant of the decision in writing.
5. Disability premium will be waived on approval of the LTD claim retroactive to the date of the eligibility of the LTD claim (i.e. after the end of the waiting period). Premiums must continue to be paid until the DMSO advises that premiums will be waived.
6. When the employee returns to work, complete a *Notice of Return to Work* form and send it to the DMSO with a copy to Selectpac Member Administration. To avoid an overpayment to the employee, we recommend that you also phone the DMSO to indicate that the *Notice of Return to Work* is in the mail.

Note: You must notify Great-West in writing of the employee's disability within six months of the end of the LTD waiting period. Otherwise, the claim will be declined.

If the employee has qualified for worker's compensation benefits or other health and/or income replacement benefits, send the DMSO an LTD claim within the time frame stated above. Otherwise, the claim will be declined.

Waiver of premium

When an LTD claim is approved, life insurance coverage, LTD coverage and Short-Term Disability (STD) coverage will continue without premium payment. If your plan includes STD coverage, STD premiums continue to be charged during the STD period. During the time when the employee is disabled and on claim, all other premiums will be charged while the plan member is insured under the plan.

The DMSO will send you a letter confirming the waiver of premium.

SHORT-TERM DISABILITY (STD)

Online claim submission

Employees may apply for disability income benefits online. To start the online process, employees should go to www.greatwestlife.com – Client Services – Forms for Group Benefits Plan Members – Standard claim forms – Apply for Disability Income Benefits.

Paper claim submission

1. Provide the employee with the *Short-Term Disability Income Benefits - Employee's Guide*, with both the employee and physician completing the appropriate sections. The employee has the option of sending the statement directly to the Disability Management Services Office (DMSO) or they can return the statement to you in a sealed envelope.
2. *Complete the Application for Group Short-Term Disability Benefits - Employer's Statement.*
3. Send the employee and employer statements to the DMSO.
4. The DMSO will process the claim and advise you and the claimant of the decision in writing.
5. When the employee returns to work, complete a *Notice of Return to Work* form and send it to the DMSO with a copy to Selectpac Member Administration. To avoid an overpayment to the employee, we recommend that you also phone the DMSO to indicate that the *Notice of Return to Work* is in the mail.

Note: You must notify Great-West in writing of the employee's disability within three months of the end of the STD waiting period. Otherwise, the claim will be declined.

Short-term disability with long-term disability coverage in place

Follow the same six-step process outlined above. If the disability extends into an LTD claim, the DMSO will contact you and the employee should any additional information be required.

When the employee returns to work, complete a *Notice of Return to Work* form and send it to the DMSO with a copy to Selectpac Member Administration. To avoid an overpayment to the employee, we suggest you also phone the DMSO to indicate that the *Notice of Return to Work* is in the mail.

GROUP CRITICAL ILLNESS INSURANCE

Claim submission

Provide the employee with the *Critical Illness Claimant Statement* and *Confidential Physician Report*, with both the employee and physician completing the appropriate sections. Note that there is a separate *Confidential Physician Report* for each covered illness. These forms are available online at www.greatwestlife.com.

Once the forms have been completed, have the employee send them to the address indicated on the forms.

Optional Critical Illness Insurance

Coverage is chosen by employees on an individual basis and is available to both the employee and the spouse. Employees do not have to apply for coverage in order for the spouse to be eligible.

For new applications and increases in coverage:

1. Complete the *Coverage Detail* portion of the *Critical Illness Evidence of Insurability* form, and then provide the form and a *Confidental Return Envelope* to each employee who wishes to apply for coverage.
2. Instruct the employees to complete the *Medical and Lifestyles Questionnaire portion of the Critical Illness Evidence of Insurability* form and return it to you in the sealed envelope.
3. Send the envelope to Selectpac Member Administration.

Great-West will advise of the approval date and amount of coverage in writing. Approval is subject to the employee being actively at work on the approval date. If the employee is absent from work on the coverage effective date, coverage will become effective on the date the employee returns to work.

If the employee's or spouse's application is declined, we'll send a letter to the employee or spouse outlining the decision. You will also be sent a letter outlining our decision. We add the new employee for you, even if you have *GroupNet*. No further action on your part is required.

For decreases or terminations in coverage:

An employee's or spouse's amount of insurance may be decreased or terminated at any time.

1. Have the employee give you written notification of the change.
2. Send the written notification to Selectpac Member Administration.

OPTIONAL LIFE

Coverage is chosen by employees on an individual basis and is available to both the employee and spouse. Employees do not have to apply for coverage in order for the spouse to be eligible.

To obtain a copy of the latest coverage level options and rates, contact your local Great-West service representative.

New applications and increases in coverage

1. Complete the *Coverage Detail* portion of the *Evidence of Insurability* form, and then provide the form and a Confidental Return Envelope to each employee who wishes to apply for coverage.
2. Instruct the employee to complete the *Medical and Lifestyles Questionnaire portion* of the *Evidence of Insurability* form and return it to you in the sealed envelope.
3. Send the envelope to Selectpac Member Administration.

Great-West may ask for more information while reviewing the application. We'll let you and the plan member know in writing if the application has been approved or declined. If approved, coverage will be effective on the date of approval.

We add the new employee for you, even if you have *GroupNet*. No further action on your part is required.

If Great-West declines the employee's or spouse's application, we'll send a letter to the employee or spouse advising of the decision. You will also be sent a letter outlining the decision.

Claim submission

For assistance with obtaining and completing claim forms, contact your local Great-West service representative or financial advisor (the agent of record on your group insurance plan).

HEALTH SOLUTIONSPLUS

Adding new employees

Enrollment of employees for plans with *Health SolutionsPlus* occurs at the same time as an employee's enrollment under the basic plan using the usual procedure for adding new employees. The full amount of *Health SolutionsPlus* credits will automatically be provided to all new employees regardless of when they join the plan, unless Great-West is notified that the amount of credits should be adjusted at the time of enrollment.

If you're using *GroupNet*, add new employees to your group plan by following the applicable procedure on *GroupNet*. Once an employee has been added, you must submit a Great-West Assisted Change (GWAC) request via *GroupNet* to set up the employee with a *Health SolutionsPlus* account. You must also submit the original signed enrollment form to Great-West, which signifies the employee's acknowledgment that the enrollment information used for *Health SolutionsPlus* is transmitted across the U.S./Canada border

Terminations

You must notify Selectpac Member Administration of all employee terminations as they occur. To terminate an employee from your plan, follow the procedures outlined in the terminations and leaves of absence section of the administration guide.

If you're using *GroupNet*, an employee can be terminated from your group plan by following the applicable procedure on *GroupNet*. Once the termination is complete, you must submit a GWAC request via *GroupNet* to terminate the employee's *Health SolutionsPlus* account.

Reinstatements

When reinstating an employee under the base group insurance plan, the employee must also be reinstated under *Health SolutionsPlus*. If an employee is reinstated within the reinstatement period, the employee's *Health SolutionsPlus* balance is reinstated.

To reinstate an employee, use the procedures outlined in the terminations and leaves of absence section of the administration guide.

If you're using *GroupNet*, an employee can be reinstated to your group plan by following the applicable procedure on *GroupNet*. Once an employee has been reinstated, you must submit a GWAC request via *GroupNet* to reinstate the employee's *Health SolutionsPlus* account.

Annual re-enrollment of employees

Great-West will send notification one month prior to the annual re-enrollment date to confirm allocation amounts of insured employees for the new policy year. Confirmation of credit allocations for each employee must be returned to Great-West prior to the annual re-enrollment date.

Changes to employee credits

Adjustments to annual *Health SolutionsPlus* credits due to a family status or lifestyle change (e.g. marriage, divorce, separation, birth of a child or death) are allowed if the employee applies within 31 days of that change. Otherwise, the credit amount change can only be made at the next re-enrollment date.

Claim submission

Claims can be submitted using the *Health SolutionsPlus* card, *Health SolutionsPlus healthcare or dentalcare claim forms*, or online through *GroupNet for Plan Members*.

Health SolutionsPlus card:

- For Traditional Plan drug expenses, plan members must first use their pay-direct drug card to claim benefits from their base plan. They can then use their *Health SolutionsPlus* card to claim benefits for any balance from their Healthcare Spending Account (HCSA) plan.
- For dental expenses and in situations where a dental office submits a plan member's claim electronically, a claim will be adjudicated first under the basic plan. The plan member may then use the *Health SolutionsPlus* card to claim benefits for any balance from his or her HCSA plan.
- If plan members choose to use their *Health SolutionsPlus* card to pay for expenses that are covered under other plans, the entire amount will be drawn from credits on the *Health SolutionsPlus* card.

Health SolutionsPlus claim forms are customized to the group benefit plan's design. You can request copies from your Great-West representative, or you and your plan members can access claim forms on *GroupNet for Plan Members*.

For assistance, contact *Health SolutionsPlus* using the inquiry line.

Co-ordination of benefits

If plan members are able to co-ordinate benefit payment with their spouses' benefits plans, they should do so first before using the *Health SolutionsPlus* card. Should plan members choose to use their *Health SolutionsPlus* card to pay for expenses that can be co-ordinated between their and their spouse's base plans, the entire amount will be drawn from dollars on the card.

Balance reload

(Note: available only for Traditional Health SolutionsPlus plans)

If plan members have used their *Health SolutionsPlus* card to pay for an expense that would have been covered under their base benefits plan, the card can be reloaded with the covered amount. This option is available to all Great-West plan members. This option is also available to covered dependants, provided the Great-West benefits plan is their primary benefits payer. For instance, if a spouse does not have coverage under a group benefits plan of his or her own, balance reload can be used. If, however, the spouse has coverage under his or her own group benefits plan, balance reload cannot be used after he or she has submitted an expense.

To submit a claim for balance reload, the plan member would either submit a claim online through GroupNet for Plan Members or by completing a *Health SolutionsPlus* claim form for a previously swiped HealthSolutionsPlus claim and sending the form to the Health and Dental Benefit Payment Office. The Health and Dental Benefit Payment Office will assess the claim and, if the claim is eligible, reload the *Health SolutionsPlus* card with the amount that was eligible to be paid under the base plan.

A *Health SolutionsPlus* plan that is not under the same policy number as the base plan is not eligible for a balance reload.

Notes:

1. Balance reloads will be processed in the same time frame as regular claims.
2. Explanation of Benefits (EOB) statements will be issued for balance reloads using the same method as regular claims (i.e. if a plan member receives EOBs via email, he or she will also receive emails confirming balance reloads).

Claim submission deadlines

Health SolutionsPlus claims must be submitted to the Great-West Benefit Payment Office before the earliest of the following:

- 60 days after the end of the plan year in which the expenses are incurred.
- The date the *Health SolutionsPlus* contract terminates, if it terminates because the employer failed to make a required payment.
- 31 days after the date the *Health SolutionsPlus* contract terminates, if it terminates for any other reason.

Health SolutionsPlus statement of claims and expenses

Monthly bills are prepared in arrears based on the claims from the previous month. The appendix includes a detailed explanation of the calculations and terms used in your *Health SolutionsPlus* statement of claims and expenses.

MEDICAL REIMBURSEMENT PLAN (MRP)

Adding new employees

Eligible employees must be pre-enrolled for MRP benefits. You must provide your local Great-West service representative with a complete list of eligible employees to be included for MRP under one class description. The eligibility section of the *Application for Group Coverage* must be completed and signed by the policyholder. An employee's eligibility will be confirmed by Great-West at the time an MRP claim is received. If we are unable to determine eligibility at that time, we will decline the claim until confirmation of eligibility is provided by the plan sponsor.

Claim submission

1. If the employee is eligible for MRP benefits, provide him or her with an MRP claim form for completion.
2. The employee completes the form, attaches the original receipts and forwards the form and receipts to the Health and Dental Benefit Payment Office.

When submitted on an MRP claim form, the claim will be adjudicated twice, first under the base plan and then under the MRP. Two cheques will be issued for one claim.

Advance payment for large MRP claims

Payment to Great-West will be required in advance in situations where claims for a plan member exceed $3,000. A confirmation letter from the Health and Dental Benefit Payment Office will be sent to the plan sponsor prior to processing the claim payment.

Claim forms

Many plan sponsors prefer to restrict access to MRP by providing this benefit to specific groups or classes of employees. To ensure that only eligible employees have access to MRP claim forms, these forms are not available online and may only be ordered by contacting your local Great-West service representative or Supply Services. For assistance regarding an MRP claim or payment, contact an MRP Customer Relations Specialist.

CONTACT AND *CORE*CONTACT (EMPLOYEE AND FAMILY ASSISTANCE PROGRAM)

Great-West, along with Shepell•fgi, provides *Contact*/*Core*Contact, Great-West's employee and family assistance program (EAP).

Great-West handles plan member and plan administration, including billing, rates and renewals. All inquiries should be directed to your local Great-West service representative. To ensure privacy and confidentiality, no identifying employee or dependant data is shared between Great-West and Shepell•fgi.

Employee changes

Report any company name changes, or the addition or deletion of an affiliated or subsidiary company, immediately to your local Great-West service representative so we can update our systems and report the change to Shepell•fgi. This will ensure employees are not denied access to services.

Administration details

Employees may not waive the *Contact* or *Core*Contact benefit. Coverage is mandatory for all employees if *Contact* or *Core*Contact is included as part of the base plan.

Shepell•fgi provides the EAP services. A Shepell•fgi account manager/service manager will guide you in developing, implementing and maintaining your EAP. For information or assistance, please call Shepell•fgi at 1-800-461-9722.

Promotional materials

To help you promote your EAP to your employees, Shepell•fgi has developed a number of promotional materials such as EAP resource guides, brochures, wallet cards, fridge magnets, posters, etc. that are available for order free of charge. You may do so by contacting Shepell•fgi directly via any of the following options:

Email: gwlmaterials@shepellfgi.com

Online: http://www.shepellfgi.com

Phone: 1-800-461-9722

SPECIALTY PRODUCTS

CANUS

CANUS is designed to provide health and dental coverage for United States residents working for Canadian employers.

Ambassador

Ambassador is designed to cover plan members on foreign assignment working for Canadian employers outside of Canada and the United States.

Welcome Plan

The *Welcome Plan* is designed to cover plan members who have recently immigrated to Canada and are in the provincial coverage eligibility waiting period.

Details regarding the administration of these specialty products are provided under separate cover. To enroll a new employee, make changes to coverage for existing employees or submit a claim for any of these speciality products, contact your local Great-West service representative or visit www.greatwestlife.com for more details.

BILLING AND PREMIUM PAYMENT

Billing process

Each month before the premium due date, Great-West prepares your billing statement and notifies you when it's ready.

- If you're using *GroupNet* – Great-West will notify you by email when your statement is ready to review online at www.greatwestlife.com.
- If you're not using *GroupNet* – You'll receive a paper copy of your statement through regular Canada Post mail.

Important notes:

- **If you submit cheques for premium payment, it's important to include your *Remittance Information* form along with your payment. This form is located at the end of your bill.**
- Premiums are due and payable on your premium due date.
- Your coverage will be terminated if Great-West does not receive your premium within 31 days. Claims incurred on or after this date will not be accepted until your account has been brought up to date.
- Your policy limits retroactive credits for terminated employees to four months from the date Great-West is notified.
- Premium credits or debits are made for complete months of coverage and are not pro-rated. For example, if an employee is hired partway through the month and becomes eligible for benefits on the 15th (for example), the coverage will become effective and no premiums will be charged for that month (based on a 1st to 31st plan). We do not issue a credit for the premium charged if an employee leaves partway through the month.
- Coverage ends for all benefits on the day the employee is terminated. If it's a layoff or leave of absence, the coverage may be continued (see coverage during layoff, leave of absence, illness or injury).

Premium payment

1. Pay the total amount due, less any payments sent to Great-West but not appearing on your statement.
2. Include your *Premium Remittance* form with your payment and send it to Group Insurance Payment Administration. For your convenience, self-addressed envelopes are available to order from Supply Services.

Payment options

You have two options regarding payment:

- Send in a cheque.
- Choose Electronic Fund Transfer (EFT), and payments will be automatically withdrawn from your bank account each month.

HELPFUL RESOURCES

Great-West Life

Group Benefits home page

http://www.greatwestlife.com/001/Home/Group_Products/Group_Benefits/index.htm

GroupNet for Plan Administration

https://groupnet-pa.greatwestlife.com/publicGnPA/signin/loginpa.public?lang=en

Forms for Plan Administrators

http://www.greatwestlife.com/001/Client_Services/Group_Plan_Administrators/selectpac/index.htm

GroupNet for Plan Members

https://groupnet.greatwestlife.com/public/signin/login.public?blank&brand=pm&lang=en

Forms for Plan Members

http://www.greatwestlife.com/001/Client_Services/Group_Plan_Members/Forms/index.htm

eClaims Provider Listing

http://files.greatwestlife.com/eclaims-providers/

The Great-West Life Centre for Mental Health in the Workplace

http://gwlcentreformentalhealth.com/index.asp

Workers' Compensation Board of Canada

http://www.awcbc.org/en/linkstoworkerscompensationboardscommissions.asp

Eligible medical expense

Canada

http://www.cra-arc.gc.ca/tx/ndvdls/tpcs/ncm-tx/rtrn/cmpltng/ddctns/lns300-350/330/llwxpns-eng.html#elastic

Quebec

http://www.revenuquebec.ca/en/citoyen/impots/guide/aideligne/ligne381.aspx

Provincial health plans

Overview and Summary

http://www.greatwestlife.com/001/Client_Services/Group_Plan_Members/Provincial_Health_Plan_Coverage/index.htm

BC Fair Pharmacare

http://www.health.gov.bc.ca/pharmacare/

Manitoba Pharmacare

http://www.gov.mb.ca/health/pharmacare/index.html

Ontario Health Insurance Plan

http://www.health.gov.on.ca/en/public/programs/ohip/

RAMQ

http://www.ramq.gouv.qc.ca/en/citizens/health-insurance/Pages/health-insurance.aspx

Canada and Quebec Pension Plans

Canada

http://www.servicecanada.gc.ca/eng/isp/cpp/cpptoc.shtml

Quebec

http://www.rrq.gouv.qc.ca/en/programmes/regime_rentes/Pages/regime_rentes.aspx

Employment Insurance (EI)

Overview of EI Programs

http://www.servicecanada.gc.ca/eng/sc/ei/index.shtml

Premium Reduction Instructions

http://www.servicecanada.gc.ca/eng/cs/prp/010.shtml

Premium Reduction Application Form

http://www.servicecanada.gc.ca/eng/cs/prp/documents/nas5022.pdf

Provincial payroll taxes

- Manitoba
- Newfoundland and Labrador
- Ontario
- Quebec

Canada Revenue Agency: Employers' guide – Taxable benefits and allowances

http://www.cra-arc.gc.ca/E/pub/tg/t4130/README.html

Revenu Québec: Taxable benefits

http://www.revenuquebec.ca/en/sepf/publications/in/in-253.aspx

Provincial Employment Standards

- BC – http://www.labour.gov.bc.ca/esb/
- AB – http://employment.alberta.ca/SFW/1224.html
- SK – http://www.lrws.gov.sk.ca/labour-standards
- MB – http://www.gov.mb.ca/labour/standards/
- ON – http://www.labour.gov.on.ca/english/es/
- QC – http://www.cnt.gouv.qc.ca/en/home/index.html
- NS – http://www.gov.ns.ca/lae/employmentrights/
- NB – http://www2.gnb.ca/content/gnb/en/departments/post-secondary_education_training_and_labour/labour.html
- PE – http://www.gov.pe.ca/labour/index.php3?number=1004723&lang=E
- NL – http://www.gov.nl.ca/lra/faq/labourstandards.html

APPENDIX

Date: _____

Dear: _____

Re: Your Great-West Life Group Insurance Program, Policy Number _____

Excess insurance coverage over the non-evidence limit

In accordance with our Great-West Life group insurance policy, you are eligible for amounts of insurance coverage over the plan's non-evidence limit(s) as outlined below:

Benefit	Non-evidence limit	Eligible Amount of Coverage
Group Life	$_____	$_____
AD&D	$_____	$_____
Short-Term Disability	$_____	$_____
Long-Term Disability	$_____	$_____

The non-evidence limit is the amount of insurance you can be approved for without having to submit medical evidence to prove insurability.

Should you wish to apply for the excess insurance coverage identified above, you must complete and submit an Evidence of Insurability form, found at www.greatwestlife.com > Client Services > Group Benefits Plan Members > Forms. Any increase in coverage will only take effect on the date your application is approved by Great-West, and premiums will be increased accordingly. If Great-West does not approve your application, you will retain coverage up to the non-evidence limits above.

Should you apply for excess coverage, you will be notified in a timely fashion whether your application has been approved or declined. Please note that you must complete and submit an Evidence of Insurability form before any application for excess coverage will be considered.

Sincerely,

Declination of Excess Insurance Coverage

After careful consideration, I understand that I have been given the opportunity to apply for the amounts of excess insurance coverage listed above, but elect not to make application at this time. I understand that I may apply for this coverage in the future and at that time will need to provide medical evidence of good health.

_____ _____

(Employee's Signature) (Date)

Date: _____

Dear: _____

RE: Retirement/Termination of Employment

The provisions of our Great-West Life group insurance plan may entitle you to convert your group life and long-term disability benefits without having to provide medical evidence of insurability. Health and dental insurance are also available to be purchased as an individual policy with Great-West.

Maintaining insurance is important for you to help ensure your family is protected against the financial hardship that can be caused by loss of life, long-term disability, or costly medical or dental expenses. Our group insurance plan gives you the option to convert some of your group benefits to an individual policy, with acceptance being guaranteed for most individuals.

Health and Dental

Great-West offers two competitive health and dental products for individuals losing their group insurance coverage:

- **Sonata Health** – for individuals under the age 60
- **PlanDirect** – for individuals up to age 75.

Several different plans are available that cover prescription drugs, basic dental, vision care, ambulance services and paramedical services. Acceptance for coverage is guaranteed provided you apply within 60 days of the date your group plan coverage terminates.

For further information regarding Sonata Health and PlanDirect, visit: www.greatwestlife.com.

Life and Long-Term Disability Insurance

The provisions of our group insurance plan allow plan members under the age of 65 to convert their life and/or long-term disability insurance to an individual policy. Your employee booklet provides specific details on conversion privileges. To be eligible, you must complete the necessary application forms and provide the first month's premium to Great-West within 31 days of losing your group coverage.

To apply for Sonata Health, PlanDirect, and life and long-term disability insurance conversions, please contact our plan's financial advisor. **Conversion options are time-limited, so prompt action is required.**

Acknowledgement

I, _____, acknowledge receipt of this letter (and the applicable application forms) so that I may consider applying for these products after my employment and benefit coverage terminate.

_____ _____

(Employee's Signature) (Date)

ABC COMPANY

HEALTH SOLUTIONSPLUS
STATEMENT OF CLAIMS AND EXPENSES
FOR THE MONTH OF
JUNE 2012

Policy #:	Policy #
Statement Date:	July 15, 2012
Terms:	Payable upon receipt

Previous balance				222.94
Payments received	June 21, 2012			1,189.26
Balance forward				(966.32)
Paid claims				625.80
Administration fees				
Administration fee		of	60.00	
8.00%	of Claims of	625.80	50.06	
Participant Summary Report				
$ -	per participant of	0	-	
Total Administration Fees				110.06
Cash Flow Interest - Rate 1.0500%				
Previous Balance - Rate Applied 7.0000%			1.28	
Payments			(0.34)	
Paid Claims & Expenses			0.32	
Total				1.26

Provincial Totals	Ontario	Quebec	Newfoundland
Claims	625.80	0.00	0.00
Expenses	110.06	0.00	0.00
Provincial Totals	735.86	0.00	0.00

Ontario Premium Tax (Claims plus expenses X 2.000%)	14.72
Ontario Retail Sales Tax (Claims plus expenses X 8.000%)	58.87
Quebec Premium Tax (Claims plus expenses X 2.6167%)	0.00
Quebec Sales Tax (Claims plus expenses plus premium tax X 9.000%)	0.00
QST #1016586842	
Newfoundland Premium Tax (Claims plus expenses X 4.167%)	0.00
Total New Charges	810.71
CURRENT BALANCE	(155.61)
DEPOSIT FLOAT	1,209.42
REQUIRED PAYMENT	**1,053.81**

If you have any questions about this statement, please contact your Great-West service representative.

Please return one copy of this statement along with your remittance to:

The Great-West Life Assurance Company
Group Insurance Payment Administration
P.O. Box 1053
Winnipeg, Manitoba
R3C 2X4

Billing Guide

Health SolutionsPlus

Understanding the calculations and terms used in your Health SolutionsPlus statement of claims and expenses.

Monthly bills are prepared in arrears based on the claims from the previous month.

Figures used in this sample are for illustration purposes only. Actual statements will vary.

Field	*Definition*
Statement Date	Completed around the 15th of the month following the date at the top of the statement
Terms: Payable upon receipt	Payment is expected immediately following receipt
Previous balance	Current balance from previous month's billing $222.94
Payments received	Payments received for *Health SolutionsPlus* during the month billed $1,189.26
Balance forward	Balance after payments have been applied to previous month balance $222.94 - $1,189.26 = -$966.32
Paid claims	Total paid claims during the month billed $625.80
Administration fees	Percentage of paid claims + monthly policy fee
Participant Summary Report	Optional report that includes an administration fee if elected. The administration charges for annual reports are $0.15 per plan member per month, quarterly reports are $0.50 per plan member per month and monthly reports are $1.50 per plan member per month
Cash Flow Interest	Interest for cash flow: Surplus - Great-West Life standard one year rate Deficit - Bank of Canada chartered prime rate +4% **Cash Flow Interest calculations:** **Previous Balance:** Previous balance x number of days in current month / 365 (days in a year) x the applicable interest rate (($222.94 x 30 days) / 365) x 7.0% = $1.28 **Payments:** Payment amount x number of days in current month from date payment received (10 days) / 365 (days in a year) x the applicable interest rate (($1,189.26 x 10) / 365) x 1.05% = -$0.34 **Paid Claims & Expenses:** Sum of paid claims and expenses x half the number of days in the current month / 365 (days in a year) x the applicable interest rate [(($625.80 + $110.06) x 15) / 365] x 1.05% = $0.32
Provincial taxes, if applicable	**Ontario Premium Tax** is calculated on the Ontario portion of Claims + Expenses (Provincial Totals), not including interest $735.86 x 2% = $14.72 **Ontario Retail Sales Tax** is calculated on the Ontario portion of Claims + Expenses (Provincial Totals), not including interest $735.86 x 8% = $58.87 **Quebec Premium Tax** is calculated on the Quebec portion of Claims + Expenses (Provincial Totals), including interest **Quebec Retail Sales Tax** is calculated on the Quebec portion of Claims + Expenses (Provincial Totals), including interest + Quebec Premium Tax **Newfoundland Premium Tax** is calculated on the Newfoundland portion of Claims + Expenses (Provincial Totals), including interest
Total New Charges	Paid claims + Administration Fees + Cash Flow Interest + provincial taxes for current month $625.80 + $110.06 + $1.26 + $14.72 + $58.87 = $810.71
Current Balance	Balance forward + Total New Charges -$966.32 + $810.71 = -$155.61
Deposit Float	Monthly float amount required to be maintained each month $1,209.42
Required Payment	Total amount required to be paid prior to the end of the month (less any payment already sent but not included on this billing) Current balance + deposit float -$155.61 + $1,209.42 = $1,053.81