ADMINISTRATION GUIDE

Group Administration

CINUP
Employee Benefits for First Nations

This guide is designed to assist you with the basic day-to-day administration of your group insurance program. If you have any questions at any time, please contact us at:

CINUP Customer Care Centre
1051 King Edward Street
Winnipeg, MB R3H 0R4

By Phone
Toll Free 1 800.665.1234
Monday through Friday between 8:30 a.m. and 5:00 p.m. CST

By Fax
Toll Free 1 833.702.4687

Email
admin@cinup.ca

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GLOSSARY OF TERMS

Definitions

Contingent Beneficiary	means an alternative beneficiary (or beneficiaries) who an employee may select in the instance where the primary beneficiary (or beneficiaries) pre-decease the employee.
Dependent	means a spouse or child who is domiciled in Canada. However, if a dependent is domiciled outside Canada, such dependent may be deemed to be domiciled in Canada provided such individual is covered under a provincial medical plan and prior written approval is obtained from the insurer.
Earnings	means the regular rate of pay of an employee paid by the employer, including dividends, but excluding bonuses, overtime pay and any non-regular form of remuneration.
Employee	means a person who is domiciled in Canada and who is employed by the employer on a permanent or contract basis for not less than the hours per week as stipulated in your Master Application. However, if an employee is domiciled outside Canada, such employee may be deemed to be domiciled in Canada provided such individual is covered under a provincial medical plan and prior written approval is obtained from the Insurer.
Enrolment Application	is the form used for an individual employee to submit his/her application for participation on the group insurance plan.
Evidence of Insurability	is the proof of good health required by the insurer in order to qualify to participate in the group insurance plan in the case of Late Applicants, or to qualify for insurance above the defined non-evidence maximum.
Late Applicant	is an employee who applies for group insurance more than 31 days after becoming eligible to participate.
Major Life Event	is a significant change in the participant's individual circumstance that would warrant a change to his/her benefit elections such as marriage, birth or adoption of a first child, divorce, death or loss of spousal insurance coverage.
Non-Evidence Maximum	means the maximum amount of insurance an employee is allowed without having to submit proof of good health.
Revocable Beneficiary	is the employee's elected beneficiary. The employee may change the revocable beneficiary without the consent of the current beneficiary.
Spouse	means a person who is domiciled in Canada and who is the legal spouse of the participant by virtue of a religious or civil marriage ceremony or the common-law spouse of the participant with whom the participant has been living in a conjugal relationship continuously for a period of at least 12 months.
Termination	means an employee is no longer eligible for insurance because he/she ceases to be an employee of your organization, or he/she transfers into a non-eligible class.
Volume	means the units of insurance coverage.
Waiting Period	is the time an employee must serve before he/she is eligible to be insured under the group plan.

Acronyms

AD&D	Accidental Death and Dismemberment
EHC	Extended Health Care
LTD	Long Term Disability
NEM	Non-Evidence Maximum
WI	Weekly Indemnity

This guide contains the basic information you need to administer your Group Insurance Plan. It is important you are familiar with the basics of the plan's administration in order for you to be able to facilitate the submission of necessary documentation on behalf of your employees. As the Plan Administrator, you are the contact person for JG Benefits Inc. and the employees of your organization. You are responsible for ensuring that all eligible employees are enrolled under CINUP for the group insurance benefits they are entitled to.

Please note: Your organization may not have elected to provide all of the benefits noted in this Guide. Any reference in this Guide made to benefits other than those listed in your Employee Booklet and/or the CINUP Master Application do not apply and should be disregarded. In the event of a discrepancy between this Administration Guide, the Employee Booklet and the group contract, the terms of the group contract will apply.

Plan Administrator Responsibilities

As the Plan Administrator for your employees' group benefits program, your responsibilities include:

- Serving as the primary contact for JG Benefits Inc. and your employees
- Submitting all required premiums
- Reporting all new enrolments, terminations and changes
- Keeping all records updated
- Ensuring all eligible employees are enrolled in the CINUP benefits program at the appropriate time
- Maintaining confidentiality of medical and other sensitive information

my-benefits®

The easiest way to administer your firm's CINUP group benefits is with *my-benefits*. Manage administrative tasks quickly and accurately – from adding employees and updating earnings to calculating payroll deductions. If you're not registered, please do so at *www.my-benefits.ca*.

Employees can also enjoy all the advantages of *my-benefits* online or on their Android™ or iOS device. With *my-benefits* they will have quick and secure online access to their group benefit coverage where benefit details can be viewed, claims can be submitted, and benefit payments can be set up to be directly deposited to their bank account.

Documentation & Correspondence

All correspondence between your organization and CINUP should be signed, dated and include the following:

- Employer's name
- Division number

If you are submitting a form on behalf of an employee, please be sure to include the following:

- Employee's full name
- Certificate number
- Employee class

INTRODUCTION

We encourage you to keep copies of all paperwork submitted to JG Benefits Inc. Emailed or faxed copies are acceptable for:

- Enrolment applications*
- Employee change requests*
- Beneficiary changes*
- Extended Health Care (EHC) and Dental claims

*The insuring company may request originals of these forms at the time of claim. We encourage you to mail the signed and dated original copies to our office for placement in the employee's file. It is not necessary to mail original EHC and Dental claims forms that were previously submitted via email or fax. However, employees should be encouraged to retain the originals in the event they are requested by the insuring company.

All forms can be found on our website *www.cinup.ca* for your convenience, or by contacting CINUP Customer Care Centre directly at 1 800.665.1234 or admin@cinup.ca.

Mandatory Participation

CINUP is a mandatory plan, meaning all eligible employees who are permanently employed and working the minimum number of hours per week as indicated in your master application are eligible for participation and *must be enrolled* on the plan after serving the applicable waiting period.

Eligible employees may not "opt out" of the plan, but may be able to waive Extended Health and/or Dental coverage. Please reference the Opting Out of Benefits section on page 12 for more details.

Protecting Your Privacy

JG Benefits Inc. is committed to protecting your privacy and ensuring the personal information of your organization and its employees remains confidential. JG Benefits Inc. will collect, use, disclose and retain personal information only for the purposes described in our Privacy Policy. A complete copy of JG Benefits Inc. Privacy Policy is available online at *http://cinup.ca/privacy.php.*

Establishing Billing Divisions

CINUP has the ability to create separate billing divisions for various entities within your organization. This feature is intended to make the allocation of costs between your internal departments clear for premium remittance, which reduces administrative time and effort for your accounts payable employee. Billing divisions are typically established at the time the organization joins the CINUP plan. However, you can request new divisions to be established at any time. Please contact your Benefits Advisor or Service Representative with any new requests for the creation or modification of billing divisions.

Billing Statement

Each month, CINUP will produce a billing statement by billing division which will list all insured employees and their corresponding benefit volumes and premium amounts by benefit.

Billing statements are produced and mailed by the 10th day of each month (or the nearest business day before) for the premiums due for the following month. Payment is due on the first of the following month. For example: January's billing statement is produced and mailed by December 10. The premiums are for the month of January and are due on January 1. Billing cycle may change, however, notice will be given.

As the Plan Administrator, you are responsible for ensuring that:

- the billing statement is paid as billed by the premium due date. We encourage you to sign up for pre-authorized debit. Please do not add or deduct charges from the invoice; and,
- where changes are required, they are submitted to the CINUP Customer Care Centre prior to the 5th day of each month in order to be processed on the current billing statement. Please note that changes received after the 5th will appear on the subsequent statement and an appropriate adjustment will be applied.

Inquiries concerning outstanding balances or payment can be directed to your Benefits Advisor or Service Representative.

Changes Impacting Billings

The following situations may affect monthly premiums:

- a new employee enrolment or an employee termination;
- the addition or termination of dependent coverage;
- a change in salary, class or division;
- the approval or termination of waiver of premium for an employee; or
- absence from work due to a layoff, leave of absence, or maternity/parental/compassionate care leave.

Please submit any additions, terminations and change requests in a timely manner to ensure our records and your billings are as current, complete and accurate as possible.

Premium Refund

Your Benefit Administrator can process plan amendments dating back six months or to the last renewal date, whichever date is the most recent. It is encouraged that changes are submitted as soon as possible to ensure there is no overpayment of premium and claims are not submitted past an employee's eligible date.

Should a terminated employee submit claims after their termination and CINUP not be advised, we would terminate that employee's coverage back to the date of the last claim and premiums would be required for the month in which the claim(s) were incurred.

Late Payments: Reminders & Claims Suspension

If premiums are not paid by the due date, a reminder notice will be sent to you. If premiums are unpaid for 90 days or more, the division will be placed in claims suspension. This means that no employee benefit claims (Vision, Health, Dental, Disability) will be paid until the outstanding premiums have been paid. Please note that if your organization has multiple billing divisions, and any single division is more than 90 days in arrears, all divisions could be placed in claims suspension.

Where premiums are in arrears, your Benefits Advisor or Service Representative will be in contact with you to resolve the issue. If premiums are in arrears for an excessive time frame, your policy will be in danger of terminating completely. In this instance, you will be notified that coverage has lapsed. Please note that your organization continues to be responsible for payment of premium in arrears up to the termination date.

Calculating Benefit Volumes

Please note that all volume and premium amounts are provided on the monthly Group Insurance billing. This section is provided for additional information purposes and to aid in your understanding of the billing.

In order to calculate the monthly premium amounts for an individual employee, you must first determine the amount of insurance the employee is eligible for. This amount is referred to as the volume of insurance. *Please refer to your organization's Master Application or Employee Booklet to confirm the options selected*.

Life Insurance Volume

If your organization has selected a level benefit for life insurance, each employee will have the same volume of life insurance and no calculation is required. Alternatively, your organization may have selected a multiple of annual salary (rounded to the next highest $1,000 increment) as the life insurance volume. By way of example: if your employee earns an annual salary of $23,450 and your organization has chosen the two times salary option, the calculation would be:

Annual salary x 2:	$23,450 x 2 = 46,900
Volume* (rounded):	$47,000

Accidental Death & Dismemberment (AD&D) Volume

The AD&D benefit mirrors the life insurance schedule, and will therefore be calculated using the same formula as the life insurance volume calculation.

Weekly Idemnity (WI) Volume

WI volumes are calculated as a percentage of weekly earnings, rounded to the next highest $1 increment. There may be a different formula for Status and Non-Status members, so please ensure you select the appropriate formula based on your organization's selection. As an example: if your employee earns $23,450 in annual salary, is a Status member, and your organization has chosen the 66.67% of weekly earnings option for Status participants, the calculation would be:

Annual Salary / 52 weeks:	$23,450 / 52 = $450.96 per week
Weekly Earnings x STD%:	$450.96 x 66.67% = $300.65
Volume* (rounded):	$301

*The total volume is subject to the overall maximum, the non-evidence maximum and standard termination provisions listed in your Master Application.

Long Term Disability (LTD) Volume

LTD volumes are calculated as a percentage of monthly earnings, rounded to the next highest $1. There may be a different formula for Status and Non-Status members, so please ensure you select the appropriate formula based on your organization's selection. Your organization may have elected to have a graded benefit on the Non-Status benefit selection.

Non-graded example: if your employee earns $23,450 in annual salary, is a Status member, and your organization has chosen the 66.67% of monthly earnings option for Status participants, the calculation would be:

Annual Salary / 12 months:	$23,450 / 12 = $1,954.17 per month
Monthly Earnings x LTD %:	$1,954.17 x 66.67% = 1,302.85
Volume* (rounded):	$1,303

Graded example: if your employee earns $43,450 in annual salary, is a Non-Status member, and your organization has chosen the 60% of the first $2,000 of monthly Earnings, plus 40% of the balance of monthly earnings option for Non-Status participants, the calculation would be:

Annual Salary / 12 months:	$43,450 / 12 = $3,620.83 per month
Monthly Earnings x LTD %:	
First $2,000:	$2,000 x 60% = $1,200
Balance of Earnings:	($3,620.83 - 2,000) x 40% = $648.33
Volume* (rounded):	$1,200 + 648.33 = $1,849

*The total volume is subject to the overall maximum, the non-evidence maximum and standard termination provisions listed in your Master Application.

Calculation of Insurance Premium

The industry standard methods of expressing the applicable rates for each type of benefit are as follows:

- Life Insurance and AD&D rates are expressed per $1,000 of volume
  - Premium = Volume / 1,000 x Rate
- LTD rates are expressed per $100 of volume
  - Premium = Volume / 100 x Rate
- WI rates are expressed per $10 of volume
  - Premium = Volume / 10 x Rate
- Extended Health Care and Dental Care premiums are expressed as a single rate or a family rate
  - Single rates apply if the employee has no eligible dependents to be insured
  - Family rates apply if the employee has eligible dependents (a spouse/common-law spouse and/or dependent children)
- The Dependent Life Insurance rate is a flat rate set for any employee who has eligible dependents to be insured. The number of dependents does not have an effect on this rate.
- Employee Assistance Program is also a flat rate for each employee participating in your Group Insurance plan.

ELIGIBILITY AND ENROLMENT

Eligibility

All permanent employees in active service are eligible to participate in the Group Insurance plan, provided that the employee:

- has completed the waiting period. Please confirm the waiting period selected by your organization in your Master Application or Employee Booklet;
- works the minimum number of hours per week as specified in your Master Application.

Employees must enrol using their true family Status, and include all eligible dependents on their enrolment application. Eligible dependents include:

- An employee's spouse or common-law spouse (defined as "a person with whom the employee has been living for the past 12 months");
- Dependent children under the age of 21;
- Children between the ages of 21 and 26, provided that the child is in full-time attendance in school and that confirmation of school attendance is provided annually;
- Developmentally or physically disabled dependent children of any age provided that satisfactory proof of disability is provided within 31 days of the limiting ages described; and/or
- "Adopted by custom" children (for example, a niece, nephew, or grandchild) may be eligible for coverage provided that acceptable supporting documentation is submitted.

Eligible provisions for temporary, seasonal and contract employees under the CINUP plan are as follows:

- Temporary and Seasonal employees are not eligible for coverage under the plan.
- An employee hired under a contract with a minimum 2 year term is eligible for coverage, provided all other eligibility requirements are met.
- Employees hired on a contract that has a specified start and end date of less than 2 years are not eligible for coverage under CINUP.

If you are unsure of eligibility of any employee, please contact your Benefits Advisor or Service Representative for more information.

New Enrolments

It is extremely important that new employees who have joined your organization apply for coverage within 31 days of becoming eligible for coverage. When enrolling new employees, please keep the following in mind:

- Be prompt when enrolling new employees into the plan.
- The employee should complete the entire form except the area to be completed by the employer. You are responsible for completing and signing the section titled "To Be Completed by the Plan Administrator".
- Employees must enrol according to their true family Status. This means if they have eligible dependents, they must enrol them for Dependent Life. However, employees may waive Extended Health and Dental Care coverage if their spouse has similar coverage through another group plan.
- The effective date of coverage is the date the employee has completed the waiting period.
- There are four classes of employees. Please ensure each employee is enrolled in the correct class:
  - Non-Status: Non-Status employee with Non-Status dependents
  - Status: Status employee with Status dependents
  - Non-Status Blend: Non-Status employee with one or more Status dependents
  - Status Blend: Status employee with one or more Non-Status dependents

- The employee should elect a beneficiary at the time of enrolment. The beneficiary's full name and relationship to the employee should be stated. If there are multiple beneficiaries listed, the total of all shares must equal 100%. The life insurance benefit will be paid to this beneficiary in the event of the death of the employee. If a valid beneficiary designation is not in place at the time of the employee's death, benefits will be paid to the employee's estate.
- All information on the enrolment form is necessary for CINUP to proceed with the enrolment. If any information is missing, the enrolment will be delayed until it is received. The Customer Care team will contact you to facilitate the collection of missing information.
- When the enrolment application is complete, retain a copy for your records, and mail the original directly to our offices at:
  Attn: CINUP Customer Care Centre
  1051 King Edward Street
  Winnipeg, MB R3H 0R4

Reinstatement/Re-Hire

If the employee is reinstated/rehired after 12 months of terminating, the employee is subject to all waiting period requirements of a regular new employee. The employee will need to complete a new enrolment application on the date of return. On the enrolment application, please note that the employee is being reinstated, and under the "date employed full-time" indicate the date the employee returned to work. Also, please note the employee's original certificate number.

If the employee is reinstated/rehired within 12 months of terminating, the employee is eligible for immediate reinstatement on the group insurance plan – no waiting period will be applied. Complete the Notice of Employee Termination/Leave/Reinstatement and submit it within 31 days of the employee's return. Please note that the employee will be treated as a Late Applicant if his/her enrolment application is not received within 31 days of rehire.

Late Applicants

Submitting a new enrolment application more than 31 days after becoming eligible for coverage may result in an employee becoming a Late Applicant. Late Applicants are required to provide proof of insurability, which could result in delayed coverage, costs to the employee for the completion of medical forms, tests, etc., or possible denial of all coverage entirely. In addition, if the Late Applicant is applying for dependent coverage, evidence of insurability must also be completed for each eligible dependent. ***Coverage for all Late Applicants will be effective only if and when the insurance company approves them. The exception is the Dental benefit which will be effective immediately, but will be limited for the first 12 months.***

Late submission of enrolment applications also may result in retroactive charges going back to the date the employee should have been enrolled, if approved for coverage.

Providing Evidence of Insurability

Proof of good health will be required if:

- An employee is a Late Applicant;
- An employee applies for dependent coverage more than 90 days after first becoming eligible for such coverage; or
- An employee is eligible and wishes to apply for an insurance amount which exceeds the non-evidence maximum as described in the employee booklet.

Where proof of good health is required, the employee and/or any dependents must complete an Evidence of Insurability form and submit it directly to our offices at:

Attn: CINUP Customer Care Centre
1051 King Edward Street
Winnipeg, MB R3H 0R4
Email: contactus@cinup.ca

As this form does contain private medical information, please ensure the employee marks the sealed envelope as "Confidential". The Evidence of Insurability form will be reviewed and adjudicated by the insurance carrier. The carrier's decision will be communicated to you by your Benefits Advisor or Service Representative and/or the Customer Care team.

Waiving the Waiting Period for an Employee

On occasion there may be a need to enrol an employee for benefits immediately, providing coverage as soon as employment starts, without applying the standard waiting period. If this situation occurs, a signed and dated request must be attached to the enrolment application, otherwise the waiting period will be applied.

Opting Out of Benefits

As the CINUP plan is a mandatory plan, employees cannot opt out of the plan. However, if an employee has similar coverage through a spouse/partner's plan, Extended Health Care and/or Dental Care coverage under CINUP may be waived. Alternatively, an employee with coverage through a spouse/partner's plan can choose to hold 'duplicate' coverage under both plans in order to increase coverage amounts.

Employees Who are Partners

Even if a husband and wife (or common-law partners) both work for your organization, each must be enrolled as a member of the plan. This ensures that each has Life Insurance, Dependent Life insurance for the partner/spouse, AD&D, and Disability coverage, which are mandatory benefits. One spouse may elect to waive the Health and Dental coverage, or both may choose to be insured under both employee plans. Please note: once this election has been made, the employees cannot change their coverage elections unless one spouse leaves the employer or a major life event occurs.

F.N.I.H.B./F.N.H.A. Coverage

Status plan members are not entitled to waive Health and Dental coverage based on F.N.I.H.B./F.N.H.A. coverage.

Employee Group Insurance Enrolment Package

Certificate of Insurance

Each employee covered under your benefit plan will receive a Certificate of Insurance reflecting the benefits he/she has with your organization. If there are any discrepancies or disagreements with the benefits or the amounts shown, please contact your Benefits Advisor or Service Representative immediately. If there is a change in an employee's family Status or coverage, an updated Certificate of Insurance will be issued.

Employee Booklet and Benefits Card

Employee Booklet and Benefits Card will be provided for each covered employee. The Employee Booklet, along with the Certificate of Insurance, provides the employee a description and explanation of the benefits they have under the CINUP program.

Termination of Insurance

If an employee is no longer eligible for coverage under the plan, then a Notice of Employee Termination/Leave/Reinstatement form must be completed and sent to our office immediately.

An employee's group insurance terminates on the date he/she ceases to be employed in an eligible class, or on the date employment terminates. When coverage terminates, the employee must be informed they are not eligible for the payment of claims incurred after the date of termination.

There may be situations where an extension of benefits is being considered as part of a severance agreement or during a leave of absence. Please contact your Benefits Advisor or Service Representative to discuss this prior to agreeing to, or arranging, any extensions of coverage. These situations must be reviewed and approved prior to coverage being granted, and cannot be submitted through *www.my-benefits.ca*.

Conversion Privilege

When life insurance coverage reduces, or ends, the employee may convert their cancelled group life coverage to an individual life insurance policy. Conversions must be applied for by the employee within 31 days of the reduction or loss of coverage, or the termination date. Complete the Request for Conversion form and give it to the employee immediately.

If insurance on a dependent spouse terminates, either because of the death of the insured employee or because of the termination of the employee's insurance, for any reason which entitles the employee to convert his/her insurance, the dependent spouse may then become eligible to convert to an individual policy of life insurance under this benefit.

Please note: Requests for conversion received by the insuring company more than 31 days after coverage is lost will not be honoured.

NOTICE OF EMPLOYEE CHANGES

It is very important that employee information is kept up-to-date at all times. This ensures that your monthly premiums are calculated based on the most recent changes, and that claims are paid quickly and accurately.

Changes in Salary or Hours Worked

If any coverage is based on earnings, salary changes must be submitted as soon as they occur. This can be done by completing a Notice of Change: Salary/Occupation/Hours form or by submitting the change online through *www.my-benefits.ca*. A change in salary or hours worked may have a direct impact on the calculation of benefits and premium.

Please note, employees who are not actively at work on the date of a salary change (for reasons other than vacation or a statutory holiday), are not eligible for any associated increase in volumes of insurance until the date they return to work.

Change of Employee Name

If an employee has a legal change of name, please have him/her complete the Employee Change Request form and return the authorized form to CINUP for processing or submit the change online through *www.my-benefits.ca*. The employee will be issued an updated Certificate of Insurance and Benefits Card.

It is a good practice to confirm if a change in beneficiary is required at the time of a name change.

Change in Dependent Coverage

An employee can change coverage from single to family, or family to single, after a Major Life Event (birth or adoption of a first child, marriage, separation, divorce or death). If the individual wishes to change from single to family coverage and does not report the change during the 90 days following the date of the change, the dependents may be considered Late Applicants.

If an employee holds dependent coverage, any subsequent dependents will be provided coverage as soon as CINUP is informed of the new dependent and eligibility has been confirmed. The employee may be asked to provide information to confirm eligibility, or a cohabitation date in the case of a common-law relationship, or adopt by custom.

To report a change in dependent coverage, the employee must complete the Employee Change Request form or submit online at *www.my-benefits.ca* and indicate the reason for the change and the date the change occurred (not the date desired or signed). Please review the form carefully to ensure that all necessary sections are completed as required by the individual employee's situation. Changes in dependent information can impact the following areas:

- Name and/or address change
- New marital status
- The addition of benefits or change of family coverage
- Waiving Health and/or Dental coverage
- Change of beneficiary

Appointment of Beneficiary

An Appointment of Beneficiary form must be completed, dated and signed by the employee and the original copy must be submitted to CINUP. If any beneficiary named is under age 18, the "Trustee/Administrator Designation" section of the form must also be completed.

Beneficiary changes are governed by the insurance laws of the province in which the employee was a resident when the initial beneficiary was appointed. The province of residence will appear on the employee's Enrolment Application. Beneficiaries are declared to be the person(s) named on the most recently dated beneficiary form. Beneficiary designations are legal documents and correction fluid or tape should not be used. Any changes made on the form should be initialed (in ink) by the employee.

The insuring company may request the original signed and dated form in the event of a claim. An inability to produce a dated and signed original form may lead to delays in payment of death benefits, or even result in payment being made to the deceased employee's "Estate" rather than the intended beneficiary.

Applying for Coverage after Previously Waiving Health & Dental

An employee that experiences a Major Life Event or whose Extended Health or Dental Care coverage terminates under a spouse's plan is eligible for coverage under CINUP if the employee applies for the lost coverage within 31 days. If the Employee Change Request is made more than 31 days after the Major Life Event or loss occurs, the employee and their dependent(s) may be considered Late Applicants and will be required to submit Evidence of Insurability.

Late submission of change applications may also result in retroactive charges going back to the date the coverage should have been amended, if approved for coverage.

An employee who previously opted out, but has not lost other coverage under the spouse's plan, may not add Health and/or Dental for the sole reason of coordinating benefits with the spouse's plan.

Applying for Coverage in Excess of the Non-Evidence Maximum (NEM)

An employee may be eligible for additional insurance amounts if the individual's volume of coverage for life or disability insurance exceeds the NEM selected by your organization.

As an example, if your organization has 2 times annual salary as the life insurance volume with an NEM of $150,000 and the employee has a salary of $90,000; the employee could be eligible for $180,000 in total life insurance. However, he is only entitled to $150,000 in coverage based on the NEM. He must provide proof of good health to qualify for the additional $30,000 in coverage.

If the individual wishes to apply for this additional coverage, he must provide proof of good health by following the process outlined in the Evidence of Insurability section of this document.

In the event that the employee applies for excess coverage beyond the NEM, but is declined by the carrier, the original NEM amount will remain in force. Although the excess amount will not be added, there will be no loss of coverage.

Changes in Class or Division

It is important that you notify CINUP of any class changes (for example, if a Status employee now qualifies as a Status Blend – or division) or division changes, along with any resulting salary or occupation changes, as soon as possible. This will ensure the employee holds the correct coverage and that premiums are billed correctly.

Temporary Leave of Absence or Layoff

An employee who ceases to be actively at work due to a temporary layoff or leave of absence may remain insured for all benefits held immediately prior to the start of the layoff or leave – with the exception of disability coverage which ceases on the last day worked – for any predetermined period (to a 6 month maximum) provided premiums continue to be remitted.

NOTICE OF EMPLOYEE CHANGES

An employee who chooses to discontinue coverage during a layoff or leave can be reinstated on the date he or she returns to work, as long as the absence does not exceed 6 months and CINUP is notified within 31 days.

Applicable to Teachers only – A Participant who ceases to be Actively at Work due to a temporary lay-off or leave of absence may remain insured for all benefits held immediately prior to the beginning of the lay-off or leave, with the exception of the Weekly Indemnity benefit and Long Term Disability benefit, unless prior approval is obtained from the Insurer for any pre-determined period and premiums continue to be remitted. However, the insurance will not be continued beyond the period indicated in the Benefit Schedule. The Insurer must be informed of the scheduled date of return to work before the beginning of the leave.

Complete the Notice of Employee Termination/Leave/Reinstatement.

Maternity, Parental and Compassionate Care Leaves of Absence

A leave of absence occurs when an employee is absent from work for a fixed period of time determined by legislation or mutual agreement between the employer and the employee; this includes maternity, parental and compassionate care leaves. Written notice for any type of leave must be submitted before the leave begins. The last day worked and the expected return to work date must be provided.

An employee who ceases to be actively at work due to a maternity, parental, or family-related leave is given the choice to continue or discontinue benefits as follows:

- all benefits remain in force;
- all benefits, except disability coverage, remain in force; or
- no benefits remain in force (discontinue all benefits).

If the employee's benefits are discontinued during a leave, they will not be eligible for benefits again until they have returned to work. If CINUP is not advised to reactivate their benefits within 31 days from the date of return, Evidence of Insurability may be required.

Regardless of whether the employee chooses to discontinue benefits during this time, or to continue all/some of the benefits, complete the Notice of Employee Termination/Leave/Reinstatement.

If an employee decides not to return to work after a leave of absence, then please follow the normal processes to terminate insurance coverage using the original expected return to work date as the termination date.

Employees on Disability Leave

If an employee is disabled or collecting a disability benefit, for example Worker's Compensation, Auto Insurance, Group Insurance, etc., premiums may be waived for some benefits. It is important that you advise us when an employee becomes disabled so we can assist you with the employee's application for premium waiver.

Benefits Card & Employee Booklet

The Benefits Card documents the employee's group and certificate number. It should be carried by the employee at all times.

Employee Booklets are a general guide to the benefits selected by the employer through the CINUP plan, and include your Certificate of Insurance providing a summary of your coverage. If there is a discrepancy between the booklet and the contract, the contract will govern. The booklets should be distributed to all employees with group insurance coverage. The Employee Booklet and Benefits Card can also be printed and/or requested through *www.my-benefits.ca*.

Employer Changes

For any changes to your organization including address, legal name, contact(s) or signing authority, please contact your Benefits Advisor or Service Representative as soon as possible to request the required paperwork.

Forms

All CINUP claim and change forms are available on our website at *cinup.ca* under the Forms tab or can be found at *www.my-benefits.ca*.

Plan Cancellation

In the event that this plan is no longer required, 30 days written notice of the cancellation must be forwarded to your Benefits Advisor or Service Representative. All outstanding adjustments must be submitted prior to, or along with, the cancellation letter as no retroactive changes can be processed after the plan has been cancelled. All outstanding claims must be received in our office within 120 days of the termination date.

CLAIMS PROCEDURES

Claims Submission

Claims are adjudicated based on the information that you and your employees submit to the plan. To ensure that claims are paid promptly, all claim forms must be fully completed and signed by the employee with original receipts attached to the claim or can be submitted electronically through *my-benefits eClaims*®. Most claims are adjudicated within 48 hours of receipt.

Paper claims may be scanned and emailed, mailed or faxed to the CINUP Customer Care Centre; please advise your employees to keep copies for their records.

Attn: CINUP Customer Care Centre
1051 King Edward Street
Winnipeg, MB R3H 0R4
Email: contactus@cinup.ca
Fax: (800) 457.8410

Accurate and efficient claims adjudication is dependent upon our system containing accurate and current employee and dependent information – we depend on you for this! Inaccurate information may result in payment delays, or even denial of a claim.

Extended Health Care

Extended Health Care coverage provides your eligible employees and their eligible dependents with financial assistance for necessary medical expenses which are not covered by provincial hospital and medical plans. Claims for hospital expenses are normally submitted directly by the hospital. Claims for other expenses should be submitted to us by the employee.

The employee must complete and sign an Extended Health Claim form, attach all original receipts, retain a copy for their records, and submit it to our office or through *my-benefits eClaims*. Employees and dependents must be eligible for coverage under a provincial health program in order to be considered eligible for CINUP Extended Health Care.

Prescription Drugs

Employees may have their prescription drug claims submitted directly to the insurer at the time of purchase by presenting their Benefits Card to the pharmacist. The pharmacist enters the information into the system and the claim is sent electronically to TELUS. The pharmacist is paid directly by TELUS for the eligible amount, and the employee is only responsible for paying the balance not covered by the plan.

Drug claims that did not go through the pay direct drug card can be submitted through *my-benefits eClaims*, or complete and submit an Employee Reimbursement Form for Drug Claims.

Travel Health

Insured travelers, physicians or hospitals should contact Voyage Assistance immediately (contact information can be found on your CINUP Benefits Card) in the following medical situations:

- The eligible employee or an eligible dependent is hospitalized or about to be hospitalized.
- The eligible employee or an eligible dependent needs assistance in locating the nearest proper medical care.
- Insurance verification is required (this may be confirmed by the physician/hospital directly through Voyage Assistance directly).

- The eligible employee or an eligible dependent is involved in an accident requiring medical treatment.
- The eligible employee or an eligible dependent has a medical problem and require translation service.
- Emergency evacuation is deemed medically necessary (arrangements will be made through Voyage Assistance).
- Any serious medical problem arises.

The employee should be prepared to give the name of the person covered, the division and certificate number and a description of the problem.

For emergency services incurred outside the province of residence, or outside Canada, the employee or the hospital should submit an itemized statement of the hospital bills within six months of the date of service. If the employee has paid all or part of the costs, he/she should submit all receipts. Be sure to advise the employee to authorize the hospital to release any additional information that may be required.

The employee must submit a completed Extended Health Claim form along with the appropriate receipts. Once received, eligible claim expenses are paid to the employee/hospital. The insurance company will coordinate the claim with the employee's provincial healthcare plan and recover any portion that is payable.

Dental Care

Dental coverage provides your employees and their eligible dependents with financial assistance for reasonable dental expenses. To expedite the processing of claims, the form should be fully completed and signed by both the employee and the dentist.

When an employee or dependent requires dental work over a pre-determined level, it is recommended that the employee submit a Treatment Plan Request (pre-determination) to the insurer. Please have the employee contact CINUP Customer Care Centre for assistance. Upon receipt of this information, the employee will be advised how much is eligible for reimbursement under the benefits plan.

Disability Benefits

Weekly Indemnity (WI) and Long Term Disability (LTD) benefits provide employees with partial replacement of lost income during periods of total disability due to accident or illness. The employee must complete the applicable elimination period and qualify for benefits. Please contact the CINUP Life & Disability Coordinator for details.

Both Weekly Indemnity and Long Term Disability claim forms consist of three parts:

- the Employee Statement, which must be completed by the employee;
- the Attending Physician Statement, which must be completed by the doctor supervising the employee's treatment; and
- the Employer Statement, which must be completed by you, the Plan Administrator.

Please instruct all parties to forward the forms to CINUP and we will submit the completed forms to the insuring company and assist with the assessment and management of the claim.

CLAIMS PROCEDURES

Life Insurance, Accidental Death and Dismemberment, and Critical Illness

To make other types of claims such as Life Insurance, Dependent Life Insurance, Optional Life Insurance, Optional Dependent Life Insurance, Accidental Death and Dismemberment, or Critical Illness please contact the Life & Disability Coordinator for assistance and we will provide you with the appropriate claim forms.

Traveling in Canada for Medical Purposes

This benefit protects your employees and their eligible dependents from the high cost of traveling within Canada to obtain medical treatment that is not available within the community. Please refer to the Employee Booklet for greater detail or contact the CINUP Customer Care Centre at 1 800.665.1234 or admin@cinup.ca for more information.

Direct Deposit of Benefit Payments

Employees can have their benefit payments deposited directly to their bank account by setting up their banking information through *www.my-benefits.ca* under Your Profile/Direct Deposit or by completing a *Direct Deposit of Health and Dental Benefit Payments* form and submitting it to CINUP Customer Care Centre.

Coordination of Benefits (COB)

If a person is covered by more than one Extended Health Care or Dental Care plan, claims will be coordinated between the plans. You can help the employee determine which insurance company should receive the Extended Health Care, Vision Care or Dental Care claim first, based on the guidelines below:

If an employee and spouse both have Extended Health Care and/or Dental Care benefits with their employers, coverage will be coordinated and claims paid following an industry-wide standard methodology:

- When the employee is the patient, send the claim to the employee's plan first.
- When the spouse is the patient, send the claim to the spouse's plan first.
- When a dependent child is the patient, send the claim to the plan of the parent whose birthday falls earlier in the calendar year. For example, if the employee's date of birth is October 15, 1968 and the spouse's birthday is January 9, 1972, the claim would go to the spouse's plan first.

If the first plan does not pay the whole amount, send the explanation of benefits (provided by the first plan), along with a completed claim form to the second plan.

In situations where parents are separated or divorced, the following order for claim submission for children applies:

1. the plan of the parent with custody of the child;
2. the plan of the spouse of the parent with custody;
3. the plan of the parent not having custody of the child; and finally
4. the plan of the spouse of the parent not having custody.

Status Employees: Coordination with F.N.I.H.B./F.N.H.A.

The CINUP Group Insurance Plan provides coverage to Status employees over and above services provided by First Nations and Inuit Health Branch's Non-Insured Health Benefits (F.N.I.H.B.) / First Nations Health Authority F.N.H.A.).

Please note the following:

Dental:	F.N.I.H.B./F.N.H.A. is considered second payer for Status employees. If your group subscribes to the Top-Up Plan, CINUP will be considered for payment amounts over and above the amount F.N.I.H.B./F.N.H.A. paid. **Please note:** All Status Basic Dental claims must first be submitted through CINUP for consideration by the group insurance carrier.
Vision:	The Vision Care plan covers the cost of prescription eyewear and eye examinations over and above the credits available through F.N.I.H.B./F.N.H.A.
Prescription Drugs:	The Benefits Card provides the TELUS Assure information required to submit claims electronically for all eligible prescription drugs not eligible under F.N.I.H.B./F.N.H.A.

CINUP FREQUENTLY ASKED QUESTIONS

General Questions

Q: Where do employees send group insurance claims?

A: 1) For faster claim reimbursement, submit online through *www.my-benefits.ca*.
2) Paper claims should be sent to:

CINUP
1051 King Edward Street
Winnipeg, MB R3H 0R4
Fax: 1 833.702.4687
Email: contactus@cinup.ca

Q: How long do employees have to send in claims?

A: Plan members have 12 months from the date of service to submit Health, Vision, & Dental claims as long as coverage is still in effect. If the employee's employment has terminated OR your organization has moved to another plan, all outstanding claims must be received in our office within 120 days of the termination date.

Q: Where do employees find their division and certificate numbers?

A: All division and certificate numbers for Health, Vision and Dental can be found on the front of the employee's Benefits Card or by logging into *www.my-benefits.ca*. If the employee does not have a Benefits Card, please contact our office for a replacement or go online at *www.my-benefits.ca* to view, print and/or request a new Benefits Card.

Q: One of my employees is going on maternity/parental leave. Do the benefits stop when the leave begins?

A: An employee going on maternity/parental leave is considered actively employed and has the option of either continuing benefits, or terminating coverage on the last day of work. If the employee decides to continue on the plan, you (as the Plan Administrator) must discuss premium payment prior to the start of the leave. To add the newborn or adopted child, an *Employee Change Request* form must be completed and sent to CINUP Customer Care Centre within 90 days of the child's birth or date of adoption, by submitting online through *www.my-benefits.ca*.

Q: An employee wants to take a leave of absence. Do benefits continue?

A: The continuation of benefits during any leave of absence requires insurance company approval. On behalf of your employer, you must submit the *Notice of Employee Termination/Leave/Reinstatement* form, prior to the employee's leave, to your Benefits Advisor or Service Representative or by submitting online through *www.my-benefits.ca* and we will make the request on your behalf. If approved, all premium payment arrangements are to be made between the employee on leave and your organization.

Q: Why did I receive a letter stating one of my employees is eligible for excess Long Term Disability, if that employee is not disabled?

A: The benefit of being part of a group insurance plan is that the insurance company will provide employees with a maximum amount of coverage with no health questions; which is referred to as a non-evidence maximum (NEM). To receive coverage beyond the non-evidence maximum, the amount of long term disability (LTD) coverage is dependent on the employee's salary.

The letter you have received indicates that due to the employee's salary, she is eligible to apply for excess long term disability coverage. The employee does not have to be disabled to apply for the excess coverage and the form does not have to be completed by a doctor.

For example, if she was insured for $2,000 (NEM) and she became totally disabled before applying for the extra coverage, her monthly benefit would be $2,000 upon approval. If she had applied for the excess coverage prior to becoming disabled, and was approved for excess coverage of $2,300, her monthly long term disability benefit would be $2,300. Please note: If an employee applies for the excess coverage and is declined, in this example she will never lose the original $2,000 due to bad health.

If you have any questions regarding this coverage, or how to complete the Evidence of Insurability form included with the letter, please call CINUP Customer Care Centre.

Extended Health Care Coverage

Q: What is covered under Extended Health benefits?

A: Under CINUP your employees have coverage for many different health services including: semi-private hospital rooms, ambulance services, private duty nursing, paramedical practitioners (massage, chiropractor, physiotherapy etc.), orthotics, and hearing aids. A complete outline of the benefits covered under the plan can be found in your Employee Booklet. If you do not have a booklet, please contact CINUP Customer Care Centre or go online to *www.my-benefits.ca* to view, print and/or request a booklet.

Q: An employee needs to purchase medical equipment not listed in the booklet. Will it be covered?

A: CINUP includes a special equipment benefit that covers the costs of eligible medical supplies/equipment up to a maximum per person, per lifetime amount, as outlined in your Employee Booklet. Items include, but are not limited to special braces, crutches, CPAP machines, and glucometers. To find out if a specific item will be covered, please call CINUP Customer Care Centre, or submit a pre-authorization letter.

Q: Do employees need a doctor's referral in order to have claims paid?

A: A doctor's referral is necessary when an employee submits claims for orthotics, purchasing wigs, cardiac therapy, as well as for the purchase of items eligible under the special equipment benefit. A complete outline of the benefits requiring a doctor's referral can be found in your Employee Booklet.

Q: Can the insurance company pay the provider of service directly?

A: CINUP offers the convenience of assignment of benefits, which allows payment to go directly to the service provider (i.e. the massage therapist, chiropractor, etc.), without having to pay for the services up front. The service provider can access the TELUS Health eClaims web application and bill their services directly to the insurance company. Services that are assignable include: massage therapy, chiropractor, physiotherapy, hospital room stays, ambulance, and some special equipment. Please note the decision to accept assignment of benefits is up to the service provider. If the provider does allow assignment of benefits, the employee must complete the assignment of benefit portion of the claim form. If they do not accept assignment of benefits, the employee will have to pay up front and make a claim for reimbursement, which can be done easily online through *www.my-benefits.ca*.

CINUP FREQUENTLY ASKED QUESTIONS

Prescription Drug Coverage

Q: What drugs are covered under CINUP?

A: Many prescription drugs are covered under the plan. If the employee needs to know if a specific drug is covered, please have him/her direct the pharmacist to provide the DIN (drug identification number) and contact CINUP Customer Care Centre at 1 800.665.1234. Our office will confirm if the drug is eligible under the plan.

Q: An employee's drug card is not working. What should I do?

A: Have the employee ask the pharmacist to call our CINUP Customer Care Centre while he/she is at the pharmacy. Please make sure they have their Benefits Card. Most problems can be corrected over the phone.

Q: An employee's doctor has given a prescription for an over-the-counter drug. Will it be covered under the plan?

A: Unfortunately, over-the-counter drugs are not covered under the plan. Eligible drugs that can only be obtained through a prescription will be considered. An over-the-counter drug, even if prescribed by a doctor, will not be covered as it can be purchased without a prescription.

Q: Are smoking cessation drugs covered?

A: Smoking cessation drugs (excluding over-the-counter drugs) which are prescribed by a physician and dispensed by a pharmacist are covered to a lifetime maximum per person as outlined in your Employee Booklet.

Dental Care Coverage

Q: How much does CINUP cover for dental services?

A: A complete list of the dental services covered under your plan can be found in your Employee Booklet. If you do not have a booklet, please go online to *www.my-benefits.ca* to view, print and/or request or you may contact CINUP Customer Care Centre to request a copy. Prior to incurring any expenses in excess of $500, employees are recommended to submit a pre-authorization letter.

Q: Does CINUP cover orthodontic services (braces) for employees' children?

A: A Treatment Plan must be submitted before beginning any course of orthodontic treatment. Confirmation of coverage can be found in your Employee Booklet.

Q: One of my employees received a statement indicating her Dental claim is not eligible. What does she do now?

A: If the employee is a Status individual, coordination of benefits with F.N.I.H.B./F.N.H.A. apply. The statement received is part of the coordination process. Please have the dental office call CINUP Customer Care Centre and we will explain the submission procedures.

Q: If the orthodontic treatment has started, does reimbursement continue beyond the maximum age for the benefit?

A: No. The coverage ends once the maximum age for the benefit has been reached.

Q: Can the dentist send claims electronically?

A: Yes, first payor claims can be sent electronically. If the dentist still needs to send the claim in by paper, please have it sent to CINUP Customer Care Centre. Claims for Status individuals must be submitted manually.

Vision Care Coverage

Q: How much can be spent on Vision Care expenses?

A: CINUP covers the cost of prescription eyewear (glasses, contact lenses, laser eye surgery and prescription safety glasses) and eye examinations. Confirmation of your coverage can be found in your Employee Booklet.

Q: How do I know how much an employee has left to spend?

A: The employee can find out how much he/she has left to spend by logging into *www.my-benefits.ca*. Under *Claims Usage/Vision Care* they will be able to see the remaining amount of coverage and next eligible service date. They may also call CINUP Customer Care Centre at 1 800.665.1234.

Q: Do glasses have to be paid for up front?

A: This will depend on the Vision Care provider. CINUP allows for assignment of benefits, meaning the Vision Care provider can direct bill and CINUP can send them a cheque or pay by direct deposit without the employee having to pay up front, however, the decision to accept the assignment is up to the provider of service.

Disability Insurance

Q: When do I notify you of a disability claim?

A: We encourage you to notify us of any claim as soon as possible so a claim decision can be made in a timely manner. Written notice of a claim must be sent within 30 days from the date the disability begins for Weekly Indemnity (WI), and 60 days after the date the disability begins for Long Term Disability (LTD).

Q: How do we file a claim?

A: The claim forms are available from our Life & Disability Coordinator at CINUP. You will need to complete the employer statement on behalf of your organization. The employee must fill out their own sections and the attending physician has a portion to complete as well. All forms must be returned to:

CINUP
1051 King Edward Street
Winnipeg, MB R3H 0R4
Attn: Life & Disability Coordinator
Fax: 1 833.702.4687
Email: disability@cinup.ca

If you require any assistance or have any disability related questions, please contact our Life & Disability Coordinator directly at 1 800.665.1234.

Q: Is the information provided by the employee confidential?

A: Yes, all the information is confidential and will not be released without the written consent of the employee.

CINUP FREQUENTLY ASKED QUESTIONS

Q: Can CINUP provide the employer with details regarding the reason for disability?

A: Privacy Legislation governs the collection, use and disclosure of the employee's personal information. CINUP will not provide any confidential information about an employee's claim, including the reason for absence.

Q: If the attending physician has charged the employee for completing the forms, will they be reimbursed?

A: Unfortunately, it is the employee's responsibility to prove they are unable to work; therefore this cost is not covered.

Q: Why are the forms so detailed?

A: The insurer needs this information to properly determine how an employee's medical limitations and restrictions prevent them from working. The Employee and Employer Statements provide information to the insurer regarding the employee's medical condition including details that may otherwise not be provided by the attending physician. The Attending Physician's Statement provides information specific to the employee's medical condition.

Q: Why do we need to provide a job description?

A: The insurance company needs to determine how the employee's medical condition prevents them from working. The insurer will review the medical restrictions and limitations provided by the employee, employer and attending physician and compare this information to the employee's job duties.

Q: Who decides if an employee is unable to work?

A: It is the responsibility of the insurer to determine if an employee is disabled and unable to work according to the terms of the policy. The attending physician provides medical information to the insurance company, however, they do not determine if an employee is disabled. It is the responsibility of the insurer to assess the individual situation relative to the terms of the policy to determine eligibility of benefits.

Q: If an employee is unable to work due to alcohol and/or drug addiction, can they submit a claim for disability benefits?

A: Yes, the insurer will consider these types of conditions as part of the disability coverage; however the employee must be in a recognized treatment centre.

Q: Once the forms are completed and sent to CINUP, what happens to the claim?

A: The insurer will review the information and they will do one of three things:

- approve the claim;
- request additional information; or
- decline the claim.

Q: If the claim is approved, how is payment of benefits made?

A: The employee has the opportunity to sign up for direct deposit of disability benefits into their bank account. Alternatively, if a manual cheque is issued, it will be mailed directly to the employee.

Q: How frequently are payments made?

A: Payments are made weekly for WI and monthly for LTD.

Q: How long will the employee continue to receive WI benefits?

A: The insurer assesses the claims based on the inability to work. The insurance company will request additional medical information from the attending physician throughout the claim period or they may request information from the employee. As long as continued disability is supported, benefits will continue on a weekly basis.

Q: If surgery is scheduled in three weeks, can the WI claim be submitted now?

A: As surgery dates can be postponed, a disability cannot be certified in advance. We suggest completing the WI claim forms a few days in advance of the surgery date and then forwarding the forms to CINUP.

Q: If the employee's attending physician indicates a return to work date and the employee's condition deteriorates, what happens to the payments?

A: If the employee's condition worsens, or if they cannot return to work as planned, their physician must submit medical evidence to support their continued inability to work. If the medical information supports continued disability, benefits will continue. If not, the insurer may close the claim.

Q: How long will benefits be paid?

A: Depending on your plan design, the maximum WI period of payment is 15 or 17 weeks, as long as medical evidence supports total disability. If it appears the employee will not be returning to work before the end of the WI period, the insurer will transition the claim to LTD Status. They may require additional information from the employee or the attending physician to do so. The maximum LTD period of payment is until age 65, as long as medical evidence supports total disability.

Q: Can payments end before the maximum WI period?

A: Yes, they can terminate the date the employee no longer meets the definition of total disability, the date they return to work, the date they fail to undergo an examination recommended by the insurance company, or the date they pass away.

Q: Can LTD payments end before age 65?

A: Yes, the employee must continually meet the definition of total disability and co-operate and participate in any examinations. If they no longer meet the definition or they do not co-operate in an examination, benefits can terminate.

Q: What happens if an employee returns to work full-time from a WI claim and they become disabled again?

A: If the current disability is related to or due to the same cause, and the employee returns to work for a period of less than 14 days, satisfying another elimination period is not required. If the condition is unrelated, a new elimination period is required. This is referred to as the Recurrent Provision of the policy.

Q: What happens if I am paying my employee during this WI Period?

A: Any wages you pay the employee will directly reduce the WI payments made by the insurance company (assuming the claim has been approved). In the event the period of disability extends beyond the 15 or 17 week benefit period, the WI claim must be submitted prior to any consideration of a LTD claim.

CINUP FREQUENTLY ASKED QUESTIONS

Q: What happens if a claim is declined?

A: If an employee claim is declined, the insurer will provide him with a letter, including the details of the assessment. The employee has the right to appeal the decision and the letter will outline the information required to consider the appeal, which may include the need for additional medical information.

Q: How does an employee make a claim for LTD benefits?

A: If your organization has WI coverage, the insurer will advise the employee of any additional requirements to transition into an LTD claim.

If your organization does not have WI coverage, please contact our office immediately following the employee's last day of work for the LTD claim forms. These forms include the Employer, Employee and Attending Physician's Statements.

Q: Once approved, when does the employee begin to receive LTD payments?

A: Once the claim has been approved and the elimination period has been satisfied, LTD payments are made monthly. If you are paying your employee during the elimination period, benefits start on the later of the end of the elimination period or the end of any salary continuance.

Q: What is an independent medical examination or assessment?

A: This is a tool used by all insurance companies to determine total disability. This tool is often used if the medical information submitted is vague or if there is some question regarding the limitations and/or restrictions preventing the employee from working. The insurance company will pay for the examination and/or assessment.

Q: What is a "pre-existing" condition?

A: If an employee receives medical treatment, consultation, care or services (including diagnostic procedures), took prescription drugs or medicines for the same condition they are claiming disability benefits, they may have a pre-existing condition. For further details regarding the pre-existing exclusion, please refer to your Employee Booklet.

Q: What happens if an employee returns to work full-time from a LTD claim and they become disabled again?

A: If the current disability is related to or due to the same cause, and the employee returns to work for a period of less than six months, satisfying another elimination period is not required. If the condition is unrelated, a new elimination period is required. This is referred to as the Recurrent Provision of the policy.

Q: In the event the employee is terminally ill, is there a survivor's benefit?

A: Yes, the benefit is paid to an eligible survivor if, at the time the employee's death occurs, their disability had continued for at least 180 days or more and the employee was eligible to receive disability benefits under this plan. The benefit is equal to three months of the gross disability payment. The employee may receive the three month survivor benefit prior to their death if they have been diagnosed with a terminal illness or condition, or if their life expectancy has been reduced to less than 12 months and they are receiving monthly payments. The employee must elect this option in writing.

DIFFERENCES THAT MATTER

SERVICE

Our team of specialists are dedicated to providing your organization with a superior level of service.

TRUST

We have built partnerships with 200 aboriginal organizations in 180 communities across Canada.

STABILITY

For over 35 years, we have worked with First Nation organizations understanding the importance of keeping benefits competitive and affordable, year after year.

INDEPENDENCE

Our experienced and specialized team works for you, not the insurance companies.

COMMITMENT

Through event and community sponsorships, we value our long-standing tradition of providing community support.

CINUP

Call 1 800.665.1234 | admin@cinup.ca

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