Administration and Claims Guide

Chambers Plan
Employee Benefits

Welcome!

You've joined Canada's leading employee benefit plan for small business. This guide is designed to help you get your Plan up and running smoothly.

This guide contains everything you will need to administer your benefit program. This guide outlines the general operation of the Plan and provides details of the forms you'll use most often. The *Benefits Guide* provides you details of the benefits chosen by your firm.

YOUR ROLE AS PLAN ADMINISTRATOR

As the Plan administrator for your firm, you have an important role to play. You must gather all initial employee information, and any subsequent changes, on a timely basis to ensure accurate premium billing and so claims can be paid quickly and accurately. If you have any questions, please don't hesitate to contact us.

YOUR LOCAL MARKETING AGENCY

Should you wish to change your benefits, your advisor's guidance can be very useful in designing a plan to meet your firm's needs, today and into the future. The name of your local Chambers Plan advisor can be found at my-benefits.ca.

PLAN ADMINISTRATOR

Johnston Group Inc. administers the day-to-day operations of Chambers Plan and any inquiries can be directed to:

CHAMBERS OF COMMERCE GROUP INSURANCE PLAN
1051 King Edward Street, Winnipeg, MB R3H 0R4

Administration inquiries: chambers@johnstongroup.ca

Claims & Coverage inquiries: info@chambers.ca
Phone: 1 800 665-3365 | In Winnipeg: 204 774-6677
Fax: 1 800 457-8410 | In Winnipeg: 204 774-6698

INSURANCE COMPANY

Where Plan documents refer to the "insurance company", they mean the organization that underwrites (insures) the benefit. Your Plan is underwritten by Desjardins Insurance, Chubb Life Insurance Company of Canada, and Sutton Special Risk/Lloyd's.

Desjardins Insurance refers to Desjardins Financial Security Life Assurance Company.

Chambers Plan Adds Value

WE'RE HERE TO SUPPORT YOUR BUSINESS AND YOUR EMPLOYEES.

The following services are built into each benefit plan at no additional cost:

my-benefits®

Easy, convenient Plan administration

The easiest way to administer your firm's Chambers Plan group benefits is with *my-benefits*. Manage administrative tasks quickly and accurately – from adding employees and updating earnings, to calculating payroll deductions. Register at **www.my-benefits.ca**.

Employees can also enjoy the advantages of *my-benefits* on their Android™ or iOS device. Using the *my-benefits* app, employees can submit claims, update banking information, set up direct deposits, check their coverage and much more. Download the app from Apple and Google Play.

Available on the iPhone App Store ANDROID APP ON Google play

TELADOC MEDICAL EXPERTS

An expert medical opinion when you need it most

When you have concerns or doubts about a diagnosis or treatment plan, Teladoc Medical Experts can help. Their leading medical experts help you make the best possible decision for your health, giving you the peace of mind you deserve.

Teladoc Medical Experts services are proudly provided to every individual covered under Chambers Plan; that includes eligible dependents as defined in the benefit plan. Plus, with the Extended Family Benefit, your parents and parents-in-law also have access.

BUSINESS ASSISTANCE SERVICE (BAS)

Providing owners with resources to help manage their business more efficiently

Many businesses can't afford to have a team of specialists on hand to help deal with unexpected problems that require an expert opinion. Chambers Plan BAS, included with every plan, is a confidential service that provides access to professional accounting, counselling, legal and human resource experts who understand the challenges business owners face. BAS includes *The Healthy Business Bookmark*™, a robust library of carefully curated HR resources, including podcasts, articles, and guides to sustaining business health.

HUGR Authentic Connections

HUGR AUTHENTIC CONNECTIONS

A wellness app designed to help employees feel connected

Through the self-guided digital program, members can measure their level of social connection, discover how to build and maintain authentic connections, and regularly share how they're feeling with those closest to them. The premium version for Chambers Plan members also includes materials to develop evidence-based skills to identify and close gaps in their social connections through iCBT (Internet-based Cognitive Behavioural Therapy). The Hugr app is available on the App Store or Google Play.

Available on the iPhone App Store | Android App on Google play

TELADOC®

TELADOC® TELEMEDICINE SERVICE*

Convenient access to quality healthcare when and where members need it most

The Teladoc telemedicine service allows employees who hold a Chambers Plan Extended Health Care option to consult with a physician about non-urgent medical matters by video conference or by phone†, from wherever they are in Canada or the United States, 24 hours a day, 365 days a year. Download the app from Apple and Google Play.

Available on the iPhone App Store | Android App on Google play

*The Teladoc telemedicine service is available to all employees who hold a Chambers Plan Extended Health Care option, as well as their dependents, at NO ADDITIONAL COST.

†In Quebec, telemedicine services must be offered by video conference.

THE FOLLOWING SERVICES ARE ALSO AVAILABLE:

Arive® Employee Assistance Program

EMPLOYEE ASSISTANCE PROGRAM (EAP) from ARIVE®

Improve employee attendance and productivity

A Chambers Plan EAP can help employees and their family members cope with difficult situations before they escalate into broader problems. The Plan's EAP provides confidential, one-on-one counselling with a designated professional.

If you haven't already opted to add a Chambers Plan EAP to your firm's plan, we encourage you to speak with your Chambers Plan advisor.

HEALTH SPENDING ACCOUNT (HSA)

Choice and flexibility for employees, cost predictability for firms

Employees can use their HSA to reimburse a wide variety of eligible medical expenses or reduce out-of-pocket costs not covered under their group plan.

Firms determine the maximum they wish to set for employees, making it easy to budget and control. Claims paid under an HSA arrangement are tax deductible, and there are no set-up fees, no annual fees and no advanced deposits.

COST PLUS REMITTANCE

Giving owners a cost-efficient and tax-effective means of supplementing existing group insurance benefits

Working with your Chambers Plan group benefit coverage, Cost Plus can cover items not paid for by your group plan, reimburse these costs on a tax-free basis to individuals, and be paid with pre-tax dollars through your company, creating a business deduction like group insurance premiums.

Plan Basics

CHAMBER/BOARD MEMBERSHIP

Remember your business (or one of its principals) must maintain a membership in a participating Chamber of Commerce or Board of Trade in order for your firm to remain eligible for Chambers Plan.

COVERAGE DETAILS

Your *Benefits Guide* and booklets explain the principal features of the Plan, but the Master Contracts held by the Chambers of Commerce Insurance Corporation of Canada apply in all cases in the event of any discrepancy.

BILLINGS

Premiums are due and payable on the first of each month, but 31 days grace are provided so your payment can reach us. If your premiums are not paid by the end of the grace period, **insurance coverage automatically terminates**.

Firms who pay their premiums monthly by cheque will be mailed a premium statement on the first of each month. Firms on the pre-authorized payment option will only be sent a premium statement whenever there is a change in the billing amount (such as the addition of an employee), unless otherwise requested.

TIP

We strongly recommend that you opt in to e-billing notifications, both for the positive ecological impact and so you're always made aware as soon as your bill becomes available. While in the *Company Profile* section of *my-benefits*, click on *Update to subscribe* to adjust these settings.

ANNIVERSARY DATE/COVERAGE RENEWAL

Premiums are reviewed each April 1st (the Plan anniversary) for all Chambers Plan groups. At this time you will see rate adjustments for Life and other coverages based on individuals' ages and salaries, as well as Health and Dental rate adjustments to reflect provincial fee guide changes and health care inflation.

TERMINATION OF COVERAGE

The Member Firm may terminate its coverage "as of" the first of any month. The Plan Administrator must submit a *Request to Terminate Firm Coverage* form at least 30 days prior to the requested date of termination.

The Insurance Company can terminate the Member Firm's coverage only for:

- non payment of premium;
- a drop below the minimum required level of employee participation in the Plan;
- failure to have a membership in a participating Chamber of Commerce or Board of Trade; and
- termination of the Group Policy for all participating firms.

Eligibility And Coverage

ELIGIBLE INDIVIDUALS

Sole proprietors, partners and employees are all eligible to apply for benefits as long as they are under age 75 and Canadian residents. They must be considered **full-time** employees and work not less than 20 hours per week. Individuals must be employed for a minimum of eight months per year. Seasonal employees are not eligible for coverage.

Employees must apply for all benefits elected by the firm. An employee or their dependents may only opt out of Health or Dental if covered under another similar plan.

Employees and their dependents must be covered under their Provincial Health plan in order to be eligible for Extended Health coverage.

If a part-time employee becomes a full-time employee, the individual's waiting period starts when full-time work begins.

DEPENDENTS

Eligible employees must apply for coverage based on their current family status. Employees must choose family coverage when they have dependents in any of the following categories unless the dependent is covered through another plan:

- a legal spouse by virtue of a civil or religious ceremony;
- a common-law spouse as soon as the couple has cohabited for a continuous period of 12 months;
- unmarried children under 21 years of age, unemployed and wholly dependent on the employee;
- unmarried children age 21 and over but under age 25 (age 26 in Quebec), in full-time attendance at an accredited school or university and wholly dependent on the employee;
- unmarried children age 21 and over, but wholly dependent on the employee because of a continued and demonstrable mental or physical infirmity. For existing plan members, the dependent child's functional impairment must have existed continuously from a time when the child was otherwise a dependent under this policy.

The definition of children includes natural, adopted, step and common-law children, but not foster children, wards or grandchildren. We will cover an individual that is not a dependent if we receive proof of legal guardianship. A request to add the dependent, accompanied by official court order documentation must be received in order to review eligibility.

For dependents who are students, the employee will be asked to confirm enrolment for the current school year.

EARNINGS

For Employees: Where an employee receives a T4 – T4A from the company, income for group insurance purposes is the same as the T4 – T4A income. This amount reflects all amounts paid to the employee including salary, fees, bonuses and taxable benefits.

For Owners/Shareholders/Key Employees of Incorporated Firms: The insurable income includes all T4/T4A amounts (salary/commissions, management fees, and bonuses) as well as T5 amounts (dividends are averaged over the last two years from T5 totals).

For Commissioned Individuals and/or Owners of Unincorporated Proprietorships and Partnerships: Insurable income is based on the "Net Income" shown under Self Employment Income on line 135 of the T1 General Return. Take the current and prior years' amounts, and base the amount of coverage on the average of the two.

PROOF OF INCOME

At time of claim, individuals may be requested to confirm their income by providing copies of current T1, T4, or T5 income tax forms. If income has been overstated, coverage will be adjusted and premiums will be refunded on the excess amount.

When Coverage Starts

New insurance begins immediately following your waiting period. This applies to all employees who, on the effective date, are at work and to those who are away on paid vacation or statutory holiday. Increases in coverage begin on the date accepted by the Insurance Company.

WAITING PERIOD

The waiting period is the period of continuous full-time employment that must be satisfied before an employee can be considered eligible for coverage. Your firm's waiting period can be viewed on *my-benefits*. This waiting period applies to all employees.

Applications received outside of the waiting period will be considered a 'Late Entrant'.

3, 6, 9, 12 month waiting period

Coverage for new employees begins immediately following the waiting period. A fully completed employee application must be received in our office within 30 days of their effective date.

If you wish to waive the waiting period for any employee, this must be indicated on the employee application and the application must be received in our office within 30 days of their date of full-time employment. The waiting period must be waived in full.

No waiting period

Coverage for new employees begins on the date of full-time employment. A fully completed employee application must be received in our office within 30 days of their date of
full-time employment.

EMPLOYEE ELIGIBILITY

Extended Health Coverage | To be eligible for Health benefits, individuals must be covered by their provincial health plan. Full-time employees who are eligible based on hours worked etc., but who do NOT yet have provincial coverage, are eligible and are entitled to all benefits the firm holds except Extended Health. Once the individual is approved provincially, **the employee has 60 days to notify Chambers Plan, at which time Health benefits will be added for the individual and any eligible family members.**

For firms with four or fewer individuals, where employees must be underwritten, coverage for eligible employees takes effect on the date the individual's application is approved by the Insurance Company, and after completion of the waiting period.

Coverage up to the guaranteed level takes effect following the firm's waiting period. Higher amounts of coverage take effect on the date the excess is approved by the Insurance Company.

ABSENT EMPLOYEES

If an individual is absent from full-time work on the effective date because of accident or sickness, coverage takes effect on the date the individual returns to active full-time work. For firms with four or fewer individuals, where employees must be underwritten, coverage will commence on the date of approval. The Plan Administrator must receive the application within **31 days** of the individual's return to active full-time work or the employee will be considered a 'Late Entrant'.

OPTING OUT OF COVERAGE

When an employee's spouse has group insurance through another firm, the employee in your company may opt out of your Health and Dental benefits. To do so, the employee must provide details of the spouse's insurance including the name of the other insurer.

When an employee's spouse loses their group insurance, employees may elect any Health and Dental benefits you offer to continue their coverage under these benefits. To do so, the employee must apply for Health and Dental benefits within 60 days of the end of the spouse's benefits. Coverage will be effective on the date the spousal coverage was lost.

If the employee misses the 60 day deadline, any request for benefit changes will be treated as a 'Late Entrant'.

REINSTATED EMPLOYEES

Coverage for an employee who has been laid-off, terminated or taken a leave of absence may be reinstated provided that employee returns within six months of the termination date and we are notified of the return in writing within **31 days**. Coverage is effective on the date of return.

Enrolment

It is the employer's responsibility to ensure employees are enrolled in the Plan at the correct time.

For firms with four or fewer employees, all eligible employees must participate in the Plan.

For firms with five or more employees, 75% of eligible employees must participate in the Plan (Quebec firms: Because of legislative requirements, all eligible employees must apply). If an employee does not want to join the Plan, the firm should have the employee sign a *Group Benefit Plan Waiver* to lessen the possibility of future problems if, for example, the employee's subsequent application for coverage is declined.

LATE ENTRANTS

A 'Late Entrant' is any eligible employee who did not complete an *Employee Application* when your firm applied for coverage, or any employee who did not enrol in the plan within 30 days following the employee waiting period. A late entrant can also be any dependent that was not added to the employee's plan when the employee first joined, or was not added within 60 days of them becoming eligible. Medical evidence of insurability will be required on the employee and dependent(s) and no coverage takes effect until the date the Insurance Company approves the application. If accepted into the Plan, 'Late Entrants' are subject to a $250 Dental benefit maximum in the first 12 months of coverage.

TIP

It's easy to lose track of deadlines for submitting insurance paperwork, so to protect your firm and your employees, we recommend submitting enrolment applications as soon as employees are hired. This way, there's no need to "remember" to enrol the employee at a later date and premiums will only be billed when the employee's coverage begins.

ENDING COVERAGE

When an employee leaves your firm, is granted a leave of absence, is laid off or goes on strike, all benefits stop following the last day of work. Employees leaving the firm mid-month are required to pay the entire month's premiums. If we are not immediately notified of an employee termination, your premium can be adjusted (backdated) to a maximum of 31 days, so long as no benefits were paid during that time.

CONVERSIONS

An individual terminating their employment may convert the group Life and Accidental Death and Dismemberment (AD&D) insurance.

The Life insurance may be converted before age 66 upon reduction or termination of coverage, in whole or in part to a whole life policy.

The application process involves:

- contacting our office advising of their intent or by submitting the *Intent to Convert Group Life Insurance Coverage* form;
- a conversion application is sent to the employee along with plan descriptions and rates; and
- the employee returning the completed conversion application within 31 days of the termination of coverage to chambers@johnstongroup.ca.

AD&D insurance may be converted before age 70 to an individual accidental loss of life policy, within 90 days of the termination of coverage and is effective the date the application is received by Chubb Life Insurance Company of Canada. Information on AD&D conversion can be obtained by submitting an *Intent to Convert Accidental Death & Dismemberment Coverage* form to us at chambers@johnstongroup.ca. AD&D conversion is not available at age 65 when the insurance reduces.

Easy, Convenient Plan Administration

The easiest way to administer your firm's Chambers Plan group benefits is with *my-benefits*. Manage administrative tasks quickly and accurately – from adding employees and updating earnings, to calculating payroll deductions. Register at www.my-benefits.ca. And to get things up and running smoothly, check out our *Quick Start Guide* found on the home page for step-by-step instructions on how to use *my-benefits*.

Employees can also enjoy the advantages of *my-benefits* on their Android™ or iOS device. Using the *my-benefits* app, employees can submit claims, update banking information, set up direct deposits, check their coverage and much more. Download the app from Apple and Google Play.

Questions about *my-benefits* or how to submit pertinent changes? Use our live 'Chat' function - We're here to help!

The *Quick Start Guide* can be found on the home page for step-by-step instructions on how to use *my-benefits*.

Have questions? Need help? Chat here!

Claiming Benefits

When you need a claim form, you can print a copy from *chamberplan.ca* or *my-benefits* under the *Forms & Tools* tab. Please note claims are not payable for any month in which the Plan has not received your premium.

CLAIM TYPE	FORM/CARD TO USE	SUBMISSION REQUIREMENTS
Extended Health and Dental		The fastest and easiest way to submit a claim is online through *my-benefits*. Alternatively, claims may be mailed to head office and must be received within 365 days from the date of service.
Prescription – Pay Direct Option	TELUS Assure Card	Employees of firms with a pay-direct option **must use their TELUS Assure card** for prescription drug purchases. If, for any reason, employees do not use their TELUS Assure card for prescription purchases, they can submit them online through *my-benefits*, or by completing an *Employee Reimbursement Form for Drug Claims* which they would send **directly to TELUS Health Solutions**.
Travel Health	Voyage Assistance Travel Health Claim	Submit ALL travel claim expenses to the Plan using the claim form. The insurance company will coordinate payments on your behalf with your provincial government plan.
Disability Benefits	Contact our Service Centre for the appropriate forms	Employees must be totally disabled and under the regular care and attendance of a licensed physician. Completed forms should be sent to the Service Centre as soon as possible to avoid delays. Weekly Indemnity claims sent more than 90 days after the onset of the disability will be declined. For Long Term Disability claims, the deadline is 30 days following the elimination period.
Critical Illness Benefits	Contact our Service Centre for the appropriate forms	We must receive written notice of a claim not later than thirty (30) days from the date a claim arose. Within ninety (90) days from the date of claim, the Employee must provide proof of diagnosis of the Critical Illness.
Life Insurance, Accidental Death & Dismemberment	Contact our Service Centre for the appropriate forms	Completed claim forms must be submitted within 90 days of the death or dismemberment.

TERMINATED EMPLOYEES

Individuals who leave your firm have 120 days from their termination date to submit any claims for eligible expenses incurred up to the end of the month in which their employment ceased.

PREDETERMINATION OF DENTAL BENEFITS

Before an individual starts treatment for any significant amount (more than $500), or treatment that includes 'major services' or orthodontics, they should confirm how much the Plan will cover. Members/Providers can submit the Pre-Determination/Estimate for assessment of service/product. Providers and Members will receive an *Explanation of Benefits* indicating how much the Plan will cover.

SUBROGATION

The Insurance Company has the legal right to be reimbursed for benefits paid to an insured if that person was reimbursed by another source or party responsible for the loss. The intent of subrogation is to ensure benefit payments do not exceed the actual loss.

COORDINATION OF BENEFITS

If an employee and spouse both have group benefits through their respective employers, insurance companies will pay Health and Dental benefits following a standard procedure.

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 year.

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

Administration Forms

When you need an administration form, you can print a copy from **chamberplan.ca** or **my-benefits.ca**. Here are the most commonly used forms and instructions on when to use them:

TIP **Most of these changes can be submitted quickly and easily through *my-benefits*.**

my benefits

EMPLOYEE APPLICATION

To be completed for all new, full-time employees. We must receive the forms within **120 days of the employee's date of full-time employment**, for the employee to not be considered a late entrant.

EMPLOYEE TERMINATION

Completed *Employee Termination* forms must be received in our office within **30 days of the employee's termination**.

EMPLOYEE REINSTATEMENT REQUEST

Completed *Employee Reinstatement Request* form must be received within **31 days of the employee's return to work.**

EMPLOYEE STATEMENT OF HEALTH/ DEPENDENT'S HEALTH

A completed *Statement of Health* must accompany the *Employee Application*:

- for all 'Late Entrants' applying for coverage, and
- for individuals who are applying for coverage above the level guaranteed to their group.

INTENT TO CONVERT GROUP LIFE/ AD&D INSURANCE COVERAGE

To be used by employees terminating coverage under Chambers Plan and wishing to convert their group Life or AD&D insurance to an individual policy.

EMPLOYEE CHANGE REQUEST

To be completed when an employee's status changes. Forms must be received in our office **within 60 days of the change**. The effective date of change of coverage is on the date of the event, not the date the request was signed or received. The following events can affect an individual's coverage:

- employee name change,
- new marital status,
- new beneficiary for Life insurance benefits,
- change in the status of duplicate coverages (the employee's spouse starts or stops similar Health or Dental insurance), and
- dependent coverage changes.

SALARY CHANGES

Disability (and some Life benefits) are based upon an employee's earnings. When you have salary changes, notify our office to ensure your employees receive the maximum benefits available based upon their current salaries.

Firms can submit salary changes any time during the year. A few times a year a firm update reminder will be sent out. This reminder will request any certificate information, salaries in particular, be kept up to date. Since benefits such as Life and Disability can be salary based, the process ensures employees are eligible for the maximum benefits available.

Privacy Policy

Johnston Group Inc. has always been, and will continue to be, committed to protecting your privacy, ensuring your personal information remains confidential.

Our privacy practices are part of a larger corporate commitment to respect individuals, from plan sponsors and participants, to our sales organization and our own employees. As a long-standing member of the financial services industry, we have always worked to ensure that our business practices prevent any breach of confidentiality and we work to maintain the highest standards of conduct.

When you, as a company or an individual, apply for coverage under a group benefits plan, you share personal information about the company, yourself, and/or family members. Johnston Group will only use, retain and disclose such information to administer the terms of your group policies and plans, including:

- confirming your eligibility for insurance coverage;
- adjudication and processing the claims you send us;
- offering you complementary products and services; or
- meeting regulatory requirements.

We will contact you and obtain your consent if it ever becomes necessary to use your information for any other purpose.

Collecting Your Personal Information

In most cases, when you sign up for your benefit program we obtain all the information we need directly from your employer or from you (from the employer's application forms, or from your enrolment form). This may include name, address, phone number, age, occupation, salary, family status and answers to basic health questions.

In some cases we may ask for additional information from the insurance industry's MIB Group, Inc. (Medical Information Bureau), health insurance companies, licensed physicians and healthcare professionals or related institutions in order to determine your eligibility for coverage.

When you make a claim for benefits, we may also collect information to determine the eligibility of the claim, and the nature of the expense. We may contact you, your healthcare professionals or other benefit providers.

All this information will be collected with the individual's knowledge and consent. We will make every reasonable attempt to keep this information accurate and current, and we ask that you advise us of changes in order to keep our records up-to-date. This will allow us to provide you with the best service possible.

Collecting Website Data

We collect information from our website visitors to improve the navigation and overall user experience on our website, for marketing purposes, and to evaluate the operation and use of our website.

Protecting Your Personal Information

We employ best practices to protect collected information from loss and unauthorized access.

Our systems are designed to prevent unauthorized access and, within our organization, we limit access to your personal information to only those individuals who administer your group plan and benefits. Each employee in our organization has signed a confidentiality agreement further protecting your personal information.

Your personal information is kept only as long as we need it to administer your group plan and fulfill regulatory obligations. Our organization has policies and procedures in place to securely delete or physically destroy all personal information when it is no longer needed.

When we deal with other persons or organizations (such as other benefit providers when settling claim payments, or when using cloud-based services), we protect the confidentiality of your personal information and ensure it is not used for any unauthorized purpose.

Disclosing Your Personal Information

We use enrolment and claim information only to administer your group benefit plan and to ensure you receive all the benefits you're entitled to receive. As a result we may disclose your personal information to:

- insurance companies and service providers providing benefits under your group contract;
- physicians or other healthcare institutions for the purpose of determining coverage eligibility, and processing and adjudicating your claims;
- your authorized representatives, such as individuals with Power of Attorney or your insurance advisor; or
- government and regulatory bodies where required by law or for the purpose of processing and adjudicating your claims.

Your Personal Information

You may at any time ask us what information we have collected about you and why we have it. We will respond to your request within 30 days and provide you with access to the information we have on file.

Your request should be submitted to us in writing and you will be required to provide proof of your identity.

This Privacy Policy has described the collection, protection and disclosure of the personal information we need to administer your group benefit program. It is your right to choose not to provide us with some or all of your personal information, or to deny us the use or disclosure of your information for certain purposes. If you exercise this right, please be aware that we may be limited in our ability or not be able to provide you with coverage under a group benefit program. It may also limit our ability to administer your group benefits, including adjudicating and processing your claims.

From Us to You

Please contact our Privacy Officer at the address below if you want to:

- better understand the kinds of information we collect,
- express any concern about our privacy policies or how we've handled information about you, or
- ask questions about our privacy policies.

Privacy Compliance Officer
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