BLUE CROSS®

ADVISOR'S GUIDE

Expertise in health and travel insurance

Last update: 2024-10

Table of Contents

1. INTRODUCTION

This guide contains the main guidelines and procedures related to the administrative cycle of an insurance contract. This document contributes to the consistency of our operations, therefore guaranteeing you and your client's quality service and compliance with recognized sound business practices.

Among other things, you will find information on:

- Submitting an application
- Contract administration
- Advisor compensation
- Submitting claims
- Our underwriting process

This guide is divided into several sections. Please refer to the table of contents to easily find the information you are looking for.

The updates since the last version are highlighted in yellow.

- As of January 11th, 2023, the following benefits from our Blue Vision product (Ontario) will no longer be available for new sales.

Express Plan:
- Life Express
- Home Health Care (Deluxe only)
- Express Plan Health Package

Global Plan:
- Extended Health Benefit (Regular, Enhanced and Catastrophe)
- Drug Benefit (Basic and Deluxe)
- Dental Care (Basic and Enhanced)
- Children's Critical Illness Package (Basic and Deluxe)

- As of February 14th, 2023, the Dropbox Sign digital signature is now accepted.

2. CONTACT US

Commissions and Contracting

Telephone	514-286-2626 1-800-361-2538 (option 2, then option 2)
Email	Quebec: commission.contracting@qc.bluecross.ca Ontario: commission.contracting@ont.bluecross.ca
Documents transmission	Documents containing personal information must be sent through the file transmission form from the secure access on the Advisor resources web page. Quebec: qc.bluecross.ca/advisor-resources Ontario: on.bluecross.ca/advisor-resources
Business hours	Weekdays (except legal holidays) from 8:30 a.m. to 4:30 p.m.
Service standards Return calls and emails	24 hours from Monday to Friday (except legal holidays)

Info-Partners

Telephone	514-286-2626 1-800-361-2538 (option 2, then option 1)
Email	Quebec: info.partners.health@qc.bluecross.ca Ontario: info.partners.health@ont.bluecross.ca
Documents transmission	Documents containing personal information must be sent through the file transmission form from the secure access on the Advisor resources web page. Quebec: qc.bluecross.ca/advisor-resources Ontario: on.bluecross.ca/advisor-resources
Business hours	Weekdays (except legal holidays) from 8:30 a.m. to 4:30 p.m.
Service standards Return calls and emails	24 hours from Monday to Friday (except legal holidays)

Health and Dental claims (For questions regarding Health and Dental claims, please advise Insureds to contact the Customer Experience Centre.)

Telephone	514-286-8353 1-844 904-8353 (option 1, then option 2)
Email	Quebec: info@qc.bluecross.ca Ontario: bco.indhealth@ont.bluecross.ca
Documents transmission	Documents containing personal information must be sent through the file transmission form on our website.
Business hours	Weekdays (except legal holidays) from 8:30 a.m. to 5 p.m.

Life and Disability claims

Telephone and fax	1-800-300-5002 1-877-590-7504
Email	Quebec: claimslife.disability@qc.bluecross.ca Ontario: claimslife.disability@ont.bluecross.ca
Documents transmission	Documents containing personal information must be sent through the file transmission form on our website.
Business hours	Weekdays (except legal holidays) from 8:30 a.m. to 4:30 p.m.
Service standards Return calls and emails	24 hours from Monday to Friday (except legal holidays)

Mailing address for the Contract Administration and Underwriting services

Quebec 1981 McGill College Avenue, Suite 105 Montreal, QC H3A 0H6	**Ontario** Ontario Blue Cross P.O. Box 4433, Station A Toronto, ON M5W 3Y7

Mailing address for health and dental claims

Quebec P.O. Box 1630, Station B Montreal, QC H3B 3L3	**Ontario** Ontario Blue Cross P.O. Box 4433, Station A Toronto, ON M5W 3Y7

Mailing address for life and disability claims

Quebec Claims, Life and Disability Insurance Department P.O. Box 1630, Station B Montreal, QC H3B 3L3	**Ontario** Ontario Blue Cross Claims, Life and Disability Insurance Department P.O. Box 4433, Station A Toronto, ON M5W 3Y7

3. NEW BUSINESS – Processing the application and issuing the contract

3.1. Service standards

Entering the insurance application	4 business days from the date of receipt of the documents
Initial assessment by Underwriting and request of additional requirements (if applicable)	3 business days from the date the new application is entered into the system
Pairing the requirements and information received	2 business days from the date of receipt of requirements/information
Underwriting assesses requirements and information received (final decision if the file is complete)	3 business days following the date the requirements/ information received is entered in the system
Issuing the contract	4 business days following the date of acceptance by Underwriting
Quality control and mailing	2 business days following issuing the contract
Entering requirements to put contract into effect (issuing requirements)	2 business days from the date of receipt of documents (complete file)

3.2. Documents to be sent through the file transmission form

Documents transmission	The following documents must be sent through the file transmission form from the secure access on the Advisor resources web page (PDF): • Insurance application, including the quotation or Summary of benefits for Mortgage Plan • Pre-authorized debit (PAD) agreement • Contract endorsement • Request for modification of an existing contract (change of address, banking information, contract cancellation, etc.) **Exception**: Authorization forms needed to obtain medical information from doctors, health professionals, hospitals, and clinics cannot be transmitted electronically. These documents require the applicant's original signatures on authorizations less than ninety (90) days old. The insurer requests the document(s) with the applicant's original signature.

3.3. Digital signature

Electronic signatures accepted	Here is the list of accepted digital signature solutions if accompanied by an authentication certificate: • Adobe Sign • Authentisign • DocuSign®* • Dropbox Sign • eZsign • IGeny • NexOne Sign • OneSpan Sign • Stylet* *DocuSign and Stylus electronic signatures do not require an authentication certificate. • Handwritten signatures (pen or stylus) sent electronically must be handwritten to be valid and not typed using a handwriting font. **Important**: Please note that we do not accept the transfer of documents from sources that are difficult to verify (example: Adobe Creative Cloud, WeTransfer, Google Drive.)

3.4. Submitting a new application

3.4.1. Accepted versions

Accepted applications are available in the “Documents” section in the Advisor resources as well as in the ‘’Documents’’ section of the Quotation tool.

The Global/Flex and Express Plans of our Blue Vision and Blue Flex products as well as the Association Program (Quebec only) can be submitted via the electronic application. For more information, see the “Electronic application” in the Advisor resources (on the Quebec website only).

3.4.2. SME Plan – Features

The SME Plan is intended for small or medium-sized enterprises. It offers members of a business a set amount of coverage with a simple declaration from the SME form. The SME Plan must be approved by Blue Cross beforehand via the "SME Pre-authorization" form, available in the Advisor resources as well as in the Quotation tool. Please refer to the following document for SME standards: SME Plan Guidelines in Québec and Ontario.

Processing insurance applications	For a new SME, all applications must be submitted by the same date. • The "SME Pre-authorization" form, duly signed by the Insurer must be sent. • A list of employees must be attached with the applications and the quotations. For a group insurance replacement, if the insured persons held a salary insurance contract with another insurer, the last billing must be provided to justify the insured amounts.
Issuing of a new SME	If the same effective date is desired for the SME, it is important to specify it in an instruction sheet. We will be able to issue on the same date all insurance applications for which the SME form declaration is signed. The effective date cannot exceed 30 days following the date of signature of the SME declaration form.
Non-eligibility for the amount granted as per the SME form declaration	If an employee is unable to sign the SME form declaration, a phone interview will be required.
Exceeding amount	The exceeding amount is the amount requested above and beyond the amount granted under the SME form declaration. While the amount granted under the SME form declaration is issued on receipt of the application, the exceeding portion must be assessed by Underwriting.
Withdrawal of the 1st premium	The first premium will be withdrawn at the time the SMEs' applications are entered into the system unless otherwise specified on the application. If, however, the only issuing requirement is the first premium, it will be withdrawn when the policy is issued.
Adding a new insured to the SME Plan	New employees have 120 days from their hiring date to sign up with the SME form declaration.
Report available for the company that is payer of the SME	Reports are sent at the beginning of each month for amounts withdrawn during the previous month and amounts to be withdrawn during the following month: • ADI-OPE-VR-0120-01 Detail of payments for the previous month. • ADI-OPE-VR-0110-01 Detail of planned pre-authorized banking or credit card transactions for the next month.

3.5. Premium for new business

Pre-authorized debit	This payment method is offered on a monthly basis. • Complete sections "Method of Payment and Pre-authorized Debit (PAD) Agreement" of the application. • Attach a void cheque. Ensure that the premium amount based on the chosen frequency is available for debit upon receipt of the application. If a withdrawal date is specified, it must be between the 1st and 28th of the month. If no date is indicated, the withdrawal date will be equivalent to that of the effective date. If the effective date falls on the 29th, 30th or 31st, the default withdrawal date will be the 28th of each month.
Credit card	Payment by credit card is available on a monthly or annual basis. • Complete the "Method of Payment" section of the application. Ensure that the premium amount established based on the chosen frequency can be charged to the credit card account upon receipt of the application.
Cheque	Payment by cheque is only available on an annual basis. • Complete the "Method of payment" section of the application. • Make a cheque payable to Blue Cross Canassurance and ensure funds are available upon receipt of the application for the annual premium amount.
Payable upon delivery	If the policy is accepted “standard”, the payment is the only delivery requirement, and we have the information on the application, it will be taken when the policy is issued.

Note that the pre-authorized debit is the only method of payment available for the electronic application.

3.6. Temporary insurance coverage

Temporary insurance coverage	Temporary insurance coverage issued by the insurer allows the insured to be covered during the assessment of the application. It is subject to certain conditions that differ depending on the product and which are detailed in the insurance application.

3.7. Internal replacement of an existing contract

Effective date	Following the acceptance of the internal replacement, the effective date of the new contract will be the next paid-up to date of the contract to be replaced to ensure continuity of coverage.
Notice of replacement	A notice of replacement is required.
Premium credit	When there is a premium credit on the replaced contract, it will be automatically transferred to the new contract.

3.8. Documents sent by the insurer

The contract and issuing requirements of the contract or coverage are sent to the MGA.

		Recipient	**CC**
Contracts	**Quick Issue Insurance** (e.g., Blue Vision/Blue Flex Express Plan)	Policyholder • Summary • Contract	Advisor • Summary
	Coverage with underwriting	MGA	N/A
Requirements	**Quick Issue Insurance** (e.g., Blue Vision/Blue Flex Express Plan)	MGA	N/A
	Coverage with underwriting	MGA	N/A

3.9. Issuing requirements

Deadline	A period of 45 days is granted from the date of transmission of the contract to receive the issuing requirements. The period may be shorter depending on the expiry date of the declarations or any other requirements received. If the requirements are not received by the deadline, the offer is no longer valid, and the file will be closed without further notice.
Premiums	The premium is required from the effective date of the contract. Therefore, it is possible that more than one premium may be charged on receipt of delivery requirements. When the last delivery requirement is the payment of the first premium, we will immediately collect the first premium when we have all the information to proceed.
Change	Any changes to the medical condition will be subject to a new Underwriting assessment.

3.10. Rescission period

Right of examination	A period of 10 days (calendar) from the date of delivery is given to the policyholder to take note of the contract. The contract can be terminated by the policyholder with a written, dated, and signed request. The contract is then declared null and void from its effective date, and any premium paid is fully refunded.

3.11. Contracts in underwriting follow-up

Advisor Communications – Contract Status	This follow-up is available on your secured access of the Advisor resources page to track the progress of the submitted insurance applications and modification requests. **Special provisions** Being underwritten: • The "Last Activity Date" column tracks the progress of activities in the file. • The "Status" column tracks the status of the file, whether it is "In Analysis", "Pending Requirement", or whether an "Action is required" in order to start or continue the file review. • Email notifications are also sent to inform you of the actions required on your part. Decisions: • The files will transfer into this section once an underwriting decision is rendered, and the details can be consulted. • An email notification is also sent to inform you of the decision.
Frequency	The information is updated in real time.

3.12. Summary of monthly renewals

Summary of contracts under renewal report	The report is available on your secured access of the Advisor resources page where you can see the renewals for the next month.
Frequency	Available on the 10th of each month.

3.13. Insurance application closure

Insurance application closure	As a result of the situations listed below, the insurance application will be closed and cancelled in our systems. • At the policyholder's request • If underwriting, issuance or implementation requirements are not received

3.14. Changing the effective date of a contract

Changing the effective date of a contract to the current date	**Criteria** • Policyholder's request • When not an internal replacement • The contract is not yet in force • Issuing requirements are received by the deadline If the above criteria are met, the contract will be issued as of the current date, either on the date of signing the endorsement or the Declaration of good health. **With a modification request** To avoid an endorsement to be signed, the modification request must be signed and dated by the policyholder.

3.15. Backdating a contract

Backdating may not be used to qualify for a benefit at any time.

New effective date allowed	Up to 3 months before the initial effective date.

4. UNDERWRITING

4.1. Underwriting requirements

4.1.1. General clarifications

Underwriting standards	• The age used is the age attained by the person to be insured on the date of signing the application. • Indicated amounts correspond to the total amount of insurance in force in the past twelve (12) months including the insurance amount requested in the application. • The Underwriting Department may request additional requirements in certain cases. • For persons to be insured aged 0 to 15, the phone interview must be completed with a parent. • When Overhead Expenses insurance is requested, 50% of the overhead expenses amount must be added to the Disability due to illness benefit to determine the requirements. • For Overhead Expenses, the "Overhead Expenses" form that is available in the Documents section of the Advisor resources page or on the Blue Vision/Blue Flex quotation tool must be submitted.

4.2. Document validity

The following chart specifies the validity period of the documents required for files to be assessed by the Underwriting Department. Beyond these periods, the documents cannot be considered by the insurer and new ones must be submitted by the insured.

Documents	Validity period
Telephone interview*	1 year*
Vital signs, Blood profile, Urine analysis and ECG	1 year
Application**	1 year**
Authorization (included in the application)	90 days

* A signed Declaration of good health is required after 90 days.
** For new business only

4.3. Financial underwriting

4.3.1. Submitting proof of income with the application

For all Disability Insurance products (including the Association Program and the SME Plan), except Monthly Indemnity and Monthly Indemnity Express, the insurer allows the insured to provide proof of income with the application. This option waives the requirement to submit evidence at the time of a claim.

Before age 49 inclusive, the person to be insured must:

- Request financial evidence in the ''Occupation Information'' section from the application and attach applicable financial evidence as indicated in the Required documents table.
- Have been in the same line of business for at least two (2) years if self-employed or a business owner.
- If the application for option at the time of application is rejected due to ineligibility, the person to be insured may request a review of their file before the age of 49 inclusive.
- The minimum monthly benefits that can be subject to the option is $1,000 and the benefit period must be five (5) years or up to age 65.

The person to be insured can also take advantage of the option if they enroll in an Association Program or SME Plan.

4.3.2. General rules

Monthly benefit	$3,499 or less	$3,500 or more
Salaried employee	No evidence unless the insured chooses to provide proof of income with the application.	Proof of income required
Self-employed worker or registered business	No evidence unless the insured chooses to provide proof of income with the application OR qualifies for the income enhancement.	Proof of income required
Incorporated business owner	No evidence unless the insured chooses to provide proof of income with the application OR qualifies for the income enhancement.	Proof of income required

4.3.3. Required documents

	Categories A, 2A, 3A and 4A	Category B
Salaried employee	T4 for the last completed year. OR T1 General (Income tax and benefit return) – Copy of pages 1 to 4 of the last completed year.	N/A
Self-employed worker or Registered business	T1 General (Income tax and benefit return) – Copy of pages 1 to 4 for the last completed year. Form T2125 – (Statement of business or professional activities) for the last two (2) completed years. The eligible income — indicated on line 9946 — will be adjusted based on the income not eligible under the contract. OR A complete copy of the financial statements for the last two (2) completed years, including the accompanying notes. The eligible income will be adjusted based on the income not eligible under the contract.	

Incorporated business owner	A complete copy of the financial statements for the last two (2) last completed years, including the accompanying notes. The eligible income will be adjusted based on the income not eligible under the contract. AND T1 General (Income tax and benefit return) – copy of pages 1 to 4 for the last completed year.	

List of eligible documents:

- ✓ T1 General or T-1 General condensed: Income tax and benefit return
- ✓ T2 General: Corporation income tax return
- ✓ T2125: Statement of business or professional activities
- ✓ T2042: Statement of farming activities
- ✓ Company's financial statements
- ✓ T4: Statement of remuneration paid
- ✓ T5: Statement of investment income and/or Appendix 4 (must include information on the dividend source)
- ✓ Provincial notice of assessment (Quebec) (for monthly amounts of $3,000 or less) or Federal comparative summary (for monthly amounts of $3,000 or less)

4.3.4. Dividends

Dividends are not usually considered for disability insurance. These amounts represent the result of past work and are not constant regarding the amount or the payment (e.g., dividends received following an investment in shares).

Note that the dividends considered in determining the annual eligible income for the current year cannot exceed the company's net income before taxes.

Eligibility criteria	• Be a self-employed worker • Be in business for at least one (1) year • Fully participate in their company • Have a profitable business

4.3.5. Income enhancement

Specifications	The income enhancement is applicable to self-employed workers and business owners included in occupational categories B, A, 2A, 3A, and 4A. The income enhancement will be considered in determining: • Income earned by self-employed workers and business owners that may entitle them to an occupational category reclassification • Amount of eligible insurance

Maximum enhancement	A 20% enhancement in the net income earned is allowed up to a maximum of $40,000 at the time the amount available for monthly benefits is determined. The income after the enhancement must never exceed the gross income. The enhancement will be calculated based on the eligible net income after expenses and before taxes, and on the lowest income of the two (2) previous years, for occupational categories B, A and 2A.
Special provision for categories 3A and 4A	For categories 3A and 4A, we take the average of the past two years.
Eligibility criteria	The person to be insured must: • Be a self-employed worker or business owner in the same line of business for at least two (2) years. • Provide personal tax returns and complete financial statements of the company for the last two (2) completed years, as indicated in the Required documents section.
Registered business	The registered business of the person to be insured must not have incurred any losses in the last two (2) completed years.
Incorporated business (corporation)	The incorporated business of the person to be insured must not have incurred any losses in the two (2) last completed years, be held by four (4) shareholders or less and at a minimum of 20% of the shares by the person to be insured. If the business is a corporation, the insurer considers the net income before taxes based on the percentage of shares held in the company and declared for the purposes of income tax, as well as the employment income on Line 101 (federal tax). The enhancement is applicable on the net income before tax of the company in the financial statements for the last two (2) completed years.
Self-employed worker or sole owner of a registered business	For a self-employed worker or sole owner of a non-incorporated company, the income earned is the gross income from which the insurer subtracts business expenses as submitted in the tax return before personal taxes.

4.3.6. Income splitting

For tax purposes, income may be split between the person to be insured and their spouse.

In this case, the spouse's portion of income may be considered in the calculation of eligible income, but the spouse may not take out insurance coverage on the split income.

Information required by the insurer	• Total amount of the income • Amount after splitting the income between the two spouses • Role of each spouse in the company • Detailed description of the spouse's duties • Copy of the financial statements of the applicant and the T4s of the spouse

4.4. Occupational category reclassification requirements

Eligibility criteria	• Work outside the home more than half the time • Have at least three (3) years of experience in the same role or five (5) years of related experience • Exceed the following income requirements for the last two years:
Reclassification from B to A, A to 2A, or 2A to 3A	Annual income of $35,000
Reclassification from 3A to 4A	Annual income of $60,000
Reclassification from A to 3A or from 2A to 4A	Annual income of $115,000
Special provision for self-employed workers	The income enhancement will be taken into consideration in determining the income earned that may entitle the insured to occupational category reclassification.

Occupational category reclassification chart

Categories*	Outside the home > 50%	3 years in the same occupation or 5 years of related experience**		Income > $35,000 x 2 years	Income > $60,000 x 2 years	Income > $115,000 x 2 years
B to A	✓	✓	✓	✓		
A to 2A	✓	✓	✓	✓		
A to 3A	✓	✓	✓			✓
2A to 3A	✓	✓	✓	✓		
2A to 4A	✓	✓	✓			✓
3A to 4A	✓	✓	✓		✓	

*Some occupations are subject to restrictions and cannot be reclassified. Refer to the "Not eligible for reclassification" column in the *Occupational categories* document.
** *Related experience*: Any experience related to the insured's field of expertise or competency, with a history of job stability.

A request for occupational category reclassification may be submitted up to five (5) years after the date of issue of a contract, under certain conditions.

Reclassification request	The insured must send the following to the insurer: • Complete an application and fill out the Occupation section • Complete a phone interview • Submit proof of income

4.5. Overhead expenses

The purpose of this benefit is to cover business expenses in the event of total disability as a result of an accident or illness.

Occupational category: AO	Not eligible
Farmers	Not eligible
Waiting period	30 days (accident and illness) 30M (30 days, except in the event of an accident or hospitalization of longer than 18 hours, where the benefit is payable on day 1)
Duration of benefits	2 years

Eligible expenses

A) Expenses related to the place of business prorated to the space used to run the business	• Rent or mortgage payments • Property tax • Water tax • Electricity • Heating including natural gas, fuel, etc. • Fixed telephone • Accounting services • Maintenance contract • Property, fire and theft insurance
Excludes	• Income taxes (personal and corporate)
B) Expenses related to machinery, equipment, or any motor vehicle (car or truck) in the proportion used to run the business	• Insurance premiums (monthly amount) • Licence plate (monthly amount) • Parking fees contract (monthly amount) • For a lease: monthly amount of the lease • For a purchase: monthly amount equivalent to interest on the loan and amortization
Excludes	• Maintenance and repair costs • Driver's licence • Fuel (petrol, propane, oil)

C) Expenses related to running the business	• Employees' wages (only for firms with five employees or less) • Business taxes and permits • Postage and postal charges • Communication services (mobile phone, internet) • Laundering • Advertising (contract) • Membership and/or registration fee with a professional association (monthly amount) • Civil or professional liability insurance (monthly amount) • Other usual fixed costs necessary to run a business
Excludes	• Any portion of a loan or lease covered by another insurer • Expenses for which the Primary Insured was not liable prior to disability • Overdue invoices (expenses occurred prior to the Primary Insured's disability) • Legal fees • Moving expenses • Travel expenses • Representation expenses • Cost of merchandise, products or services sold • Professional books • Accessories, equipment, or supplies • Primary Insured's salary or that of any colleague replacing them

4.6. SME Plan standards

Intended for small or medium enterprises	• The SME Plan is intended for small or medium-sized enterprises. It offers members of a business a set amount of coverage with a simple declaration from the SME form. • The SME plan must be approved by the Insurer. • New employees of the SME have 120 days from their hiring date to sign up under the existing insurance policy.
Exceeding amount	• The exceeding amount is the amount requested above and beyond the amount granted under the SME form declaration. • While the amount granted under the SME form declaration is issued upon receipt of the application, the exceeding portion must be reviewed by Underwriting. • The Underwriting assessment is based on the total insured amount (amount granted under the SME form declaration + exceeding amount) and the requirements are set accordingly. • The exceeding amount may be approved as standard or approved with an extra premium and/or exclusion, or it may be declined.

Underwriting approval scenarios

Approved standard	Approved with exclusion	Approved with an extra premium
The (12/12) exclusion for pre-existing conditions **does not apply.** **** When there is a claim, the pre-existing conditions will be verified for the amount granted under the SME declaration form, and incontestability verification will be done for the total amount. If the person to be insured would like the option to submit their proof of income with the application, they must submit the proof set out in the "Required documents" table.	The (12/12) exclusion for pre-existing conditions **does not apply.** An exclusion applies to the exceeding amount for the duration of the contract unless a reconsideration date has been set. AND For the first 12 months*, this exclusion also applies to the amount granted under the SME declaration form. **** When there is a claim, the pre-existing conditions will be verified for the amount granted under the SME declaration form, and incontestability verification will be done for the total amount. If the person to be insured would like the option to submit their proof of income with the application, they must submit the proof set out in the "Required documents" table.	An extra premium applies to the exceeding amount. The (12/12) exclusion for pre-existing conditions **applies** (not specified in the endorsement). **** When there is a claim, the pre-existing conditions will be verified for the granted amount under the SME declaration form, and incontestability verification will be done for the total amount. If the person to be insured would like the option to submit their proof of income with the application, they must submit the proof set out in the "Required documents" table.

***Example**

Insurance request:

- Amount granted under the SME form declaration: $1,500
- Exceeding amount: $500

After underwriting analysis, the entire insurance request is approved with an exclusion for the right knee.

The contract endorsement sent with the contract will state that:

- The (12/12) exclusion for pre-existing conditions does not apply for that condition.
- The exclusion will apply to $2,000 (entire insured amount) for (1) year.
- As of the second year of coverage, the exclusion will apply only to $500 (exceeding amount).

4.7. Underwriting standards for Association Program

The Association Program is the result of an agreement between the insurer and a partner for an association	• The Association Program offers members of an official organization other than a business a set amount of coverage with a simple declaration.
General enrolment requirements for each member	• A person to be insured may only apply once to take advantage of the associated privileges. • The amount of time spent working for the association is not an eligibility criterion. For instance, if the person to be insured is a member of the Professional Massotherapists Association of Quebec, but only spends 20% of their time doing that and works as an esthetician 80% of the time, they can still apply for insurance.
Exceeding amount	• The exceeding amount is the amount requested above and beyond the amount granted under the Association form declaration. • While the amount granted under the Association form declaration is issued upon receipt of the application, the exceeding portion must be studied by Underwriting. • Underwriting's analysis is based on the total insured amount (amount granted under the Association form declaration + exceeding amount) and the requirements are set accordingly. • The exceeding amount may be approved as standard or approved with an extra premium and/or exclusion, or it may be rejected.

Underwriting approval scenarios

Approved standard	Approved with exclusion	Approved with an extra premium
The (12/12) exclusion for pre-existing conditions **does not apply.** **** When there is a claim, the pre-existing conditions will be verified for the amount granted under the Association form declaration and incontestability verification will be done for the total amount. If the person to be insured would like the option to submit their proof of income with the application, they must submit the proof set out in the "Required documents" table.	The (12/12) exclusion for pre-existing conditions **does not apply.** An exclusion applies to the exceeding amount for the duration of the contract, unless a reconsideration date has been set. AND For the first 12 months*, this exclusion also applies to the amount granted under the Association form declaration. **** When there is a claim, the pre-existing conditions will be verified for the amount granted under the Association form declaration and incontestability verification will be done for the total amount. If the person to be insured would like the option to submit their proof of income with the application, they must submit the proof set out in the "Required documents" table.	An extra premium applies to the exceeding amount. The (12/12) exclusion for pre-existing conditions **applies** (not specified in the endorsement). **** When there is a claim, the pre-existing conditions will be verified for the amount granted under the Association form declaration, and incontestability verification will be done for the total amount. If the person to be insured would like the option to submit their proof of income with the application, they must submit the proof set out in the "Required documents" table.

***Example**

Insurance request:

- Amount granted under the Association form declaration: $1,500
- Exceeding amount: $500

After underwriting analysis, the entire insurance request is approved with an exclusion for the right knee.

The contract endorsement sent with the contract will state that:

- The (12/12) exclusion for pre-existing conditions does not apply.
- The exclusion will apply to $2,000 (entire insured amount) for (1) year.
- As of the second year of coverage, the exclusion will apply only to $500 (exceeding amount).

4.8. MIB, Inc.

Brief description	• MIB, Inc. is a corporation whose members are life and disability insurance companies in North America. • Its mandate is to detect and reduce insurance fraud. • Its mission is to keep insurance premiums affordable for all consumers by helping the industry reduce fraud and adverse selection.
A simple process	• It collects medical and non-medical information on insureds from its members in a coded format. • It ensures the security of coded information. • With authorization, it sends the codes to its members, without compromising the security or confidentiality of insureds' personal information.
Obtaining information in the MIB, Inc. file	• MIB, Inc. allows consumers to access information in their file through its website: www.mib.com. • Insured persons have the right to contest the accuracy of information or the fact that their file is incomplete by sending a written request to the following address: MIB, Inc. 50 Braintree Hill Park, Suite 400 Braintree, MA 02184-8734 Infoline@mib.com

4.9. Contract Administration

4.9.1. Service standards

Entering an insurance application	Two (2) business days from the date of receipt of the application and required documents.

4.10. Documents to be sent through the file transmission form

Documents transmission	The following documents must be sent through the file transmission form from the secure access on the Advisor resources web page (PDF): • Insurance application, including the quotation or the summary of benefits – Mortgage Plan • Pre-authorized debit (PAD) agreement • Contract endorsement • Request for modification of an existing contract (change of address, banking information, contract cancellation, etc.) The original of any document sent must be kept by the advisor for the duration of the contract.
Exception: Authorizations to release medical information	Authorization forms needed to obtain medical information from doctors, health professionals, hospitals, and clinics cannot be transmitted electronically. These documents require the applicant's original signatures on authorizations less than ninety (90) days old. The insurer requests the document(s) with the applicant's original signature.

4.11. Modification request without underwriting

4.11.1. Miscellaneous changes

Change of policyholder	Upon receipt of a signed and dated request from the current policyholder and the new policyholder.
Change of beneficiary	Upon receipt of the signed and dated Beneficiary designation form.
Change of address	Upon receipt of a request indicating the new address.
Change of billing	Upon receipt of a request indicating the new billing frequency. The change of billing frequency must be made on the renewal date of the contract.
Change of advisor	A signed and dated request from the policyholder is required. Here is the information that must be included in the request: • Policy number • First and last name of policyholder • First and last name of the advisor • Advisor code The request will be processed within 10 days from the date of receipt.
Reducing the insurance amount for Disability – Mortgage Plan	On receipt of a written request, dated and signed by the policyholder, we will reduce the sum insured for the disability as of the next "paid to date."

Increasing the insurance amount for Disability – Mortgage Plan	If the increase in the insured amount is less than 50% of the current insured amount, a dated and signed written request or the Mortgage Plan renewal form will be required. This change will not require underwriting. If the increase is more than 50% of the amount insured, this application will require underwriting. The required documents are: • A new duly completed and signed application • Summary of benefits – Mortgage Plan For a monthly premium payment frequency, it will be added to the next "paid to date" following receipt of the request. For a quarterly and annual premium payment frequency, the addition will be made on the date the document is received. At the policyholder's request, we agree to proceed to the next "paid to date" following the request.
Increasing the insurance amount for Life Insurance – Mortgage Plan	This change goes through Underwriting regardless of the amount added. The required documents are: • A new duly completed and signed application • Summary of benefits – Mortgage Plan For a monthly premium payment frequency, it will be added to the next "paid to date" following receipt of the request. For a quarterly and annual premium payment frequency, the addition will be made on the date the document is received. At the policyholder's request, we agree to proceed to the next "paid to date" following the request.

4.11.2. Adding Dental benefits (Blue Flex only)

Required document for a new application	• A new duly completed and signed application • A quotation, completed, signed, and dated by the policyholder
Effective date	• For a monthly premium payment frequency, it will be added to the next "paid to date" following receipt of the request. • For a quarterly and annual premium payment frequency, the addition will be made on the date the document is received. At the policyholder's request, we agree to proceed to the next "paid to date" following the request.
Upon re-enrolment of the coverage	If the policyholder terminates the Dental Care coverage, it is no longer possible to re-enroll unless the policyholder can prove that they were covered by the Dental Care coverage under another contract during this period.

4.11.3. Adding Express benefits

Required documents for a new application	• A new duly completed and signed application • A quotation, duly completed, signed, and dated by the policyholder
Effective date	The effective date is the day after the policyholder signs the application.

4.11.4. Reducing an insurance amount, removing a benefit, or removing an insured from a policy

Required information	To remove a benefit from the coverage in force, the policyholder must submit a signed and dated letter. The following information must be included in the request: • Contract number • Policyholder's first and last name • The specifications of the request for reducing an insurance amount, benefit or insured from the policy.
Effective date of modification	• **For a monthly premium payment frequency**, it will be added to the next "paid to date" following receipt of the request. • **For a quarterly and annual premium payment frequency**, the modification will be made on the date the request is received. At the policyholder's request, we agree to proceed to the next "paid to date" following the request.

4.12. Modification request with underwriting

4.12.1. Standards for adding a benefit, upgrade coverage (including reconsidering an exclusion or extra premium), or adding an insured to the coverage

Adding or modifying a benefit and upgrading existing coverage	To add a benefit or upgrade existing coverage, you must submit a new application. To do so, you must: • Complete a new application. • Check the change box on page 1 and write the policy number. • Have the appropriate application declaration(s) signed and dated by the policyholder. • Attach a copy of the dated and signed quotation. A phone interview will be requested. Please note that the electronic application can be used for new business only. It cannot be used for a contract modification.

Adding a child or spouse	To add an insured to the policy, you must submit a new application. To do so, you must: • Complete a new application. • Check the change box on page 1 and write the policy number. • Complete section spouse/dependent children on the application. • Have the appropriate application declaration(s) signed and dated by the policyholder and the spouse if applicable. • Attach a copy of the dated and signed quotation. A phone interview will be requested. Please note that the electronic application can be used for new business only. It cannot be used for a contract modification. For the Blue Vision, Blue Flex, Basic Blue Choice and Blue Choice Balance products: • **In a single-parent or family plan**, a child born after the date the policy is effective is automatically covered as a dependent. A new application signed by the policyholder, with the spouse/dependent child(ren) section completed, must be sent to us for the change to be made to the contract. • **In a single or couple plan**, a child born after the date the policy is effective is automatically covered as a dependent, provided that the request be received within 30 days following the birth. After 30 days, proof of insurability will be required. For the Blue Choice product: • A child born after the date the policy is effective is automatically covered as a dependent, provided that the request be received within 30 days following the birth. To do so, a new application signed and dated by the policyholder, with the spouse/dependent child(ren) section completed, must be sent to us. After 30 days, proof of insurability will be required.
Effective date of addition	The date the application is approved by the Underwriting Department.
Premium withdrawal date	The withdrawal will be made when the contract modification is issued.

4.12.2. Possible addition on an effective policy

Modification requiring a new policy	For all Blue Vision/Blue Flex contracts that includes a disability benefit issued before June 1st, 2016, the addition of certain benefits or increases in insured amounts must be made on a new policy.
Blue Vision/ Blue Flex	• Disability due to Accident • Disability due to Illness • Term Life 65 • Overhead Expenses
Mortgage Plan	• Mortgage Disability • Mortgage Life
Effective date	The date of Underwriting decision.
Premium withdrawal date	The withdrawal will be made when the contract is issued or put in force if a requirement is needed.
Required documents	• A new application (check the change box on page 1 and enter the policy number) • A completed, signed and dated quotation

Modification to existing contract	Certain modifications must be made to the existing policy.
Type of modification possible and effective date	The effective date will be the next paid-up date for the following changes: • Increase of the waiting period • Decrease in duration of benefit • Removal of the automatic increase • Levelled premium and removal of the indexation • Decrease of the sum insured • Removal of a benefit • Change of occupational category (**lower class**) The effective date will be the date the application is accepted by Underwriting for the following changes: • Decrease in the waiting period • Increase in the duration of benefits • Addition of indexation • Change of occupational category (**higher class**)
Premium withdrawal date	The withdrawal will be made when the contract is issued or put in force if a requirement is needed.
Required documents	• A new application (check the change box on page 1 and enter the policy number) • A completed, signed and dated quotation

4.12.3. Changing status to non-smoker

Required documents	To do so, you must submit the following documents: • A Short Health Statement with the “non-smoker rate” box checked • Medical authorization • The Questionnaire regarding tobacco usage • A urine HIV test if the insured amount is greater than $3,000 in disability insurance and $250,000 in life insurance Refer to the eligibility criteria in the "Non-smoker status" section. If the insurance policy was issued at the smoker rate and the insured has quit using tobacco products of any kind for over 12 months, they may ask to have it changed to the non-smoker rate. The request must be assessed by Underwriting.
Decision accepted	A contract summary is sent.
Effective date	The effective date will be the next paid-up date.

4.13. Cancelling a contract

Required document for a cancellation request	To cancel a policy, the policyholder must submit a signed and dated letter. The following information must be included in the request: • Policy number • First and last name of policyholder • Cancellation request The policy will be cancelled on the next "paid to date" following the date of receipt of the signed cancellation request. When a cancellation request is received directly from the policyholder, an email notification will be sent to you. We will grant you 10 business days to clarify the situation with your client.
Cancellation upon death of the insured	A death certificate must be sent to the insurer to terminate the policy of an insured who is deceased. If applicable, we will refund to the Estate the premiums paid since the date of death. For more information on life insurance claims, refer to "Life Insurance Claims" section.
Cancellation by the insurer for non-payment	The Insurer grants a grace period of 30 days as of the due date, except in for the first premium, which must be paid before the insurance comes into effect. If the premium remains unpaid at the end of the grace period, the Insurer will mail a notice to the payer and the policyholder at the last known address indicating that the contract will be terminated retroactive to the due date unless the premium is paid within 15 days. If the delay elapses and the contract is cancelled, the policyholder will then have to request its reinstatement. You will receive copies of any correspondence sent to your client, except for the initial billing notice, so you can follow up with your client to keep the policy from being cancelled.

4.14. Reinstatement request

If a contract has lapsed following non-payment of the premium, it can be reinstated at the Insurer's discretion, according to the following guidelines (lapsed contact).

Time elapsed since premium due date	Reinstatement guidelines
30 days or less (grace period)	• Payment of the balance due
31 to 45 days*	• Payment of the balance due
46 to 90 days**	• Short Health Statement (including the policy number) • Payment of the balance due
More than 90 days	• New insurance application (including the policy number) • Payment of the balance due

*As of the **31st day** following non-payment of the premium, the insurer has the right to deny any claim submitted.
On the **46th day following non-payment of the premium, the reinstatement request is forwarded to the Underwriting Department for assessment.

Under the provisions of the policy, the insurer reserves the right to require proof of the insured's medical condition.

4.15. Payment returned from the bank

Bank return of 1st premium	When the first (1st) premium is returned unpaid from the bank, the insurance contract will lapse, and the contract will be considered as never having been in force. A lapse notice will be sent to the policyholder and/or payer, if different from the policyholder.
Bank return of subsequent premiums	If a subsequent premium is returned unpaid from the bank, the insurer will mail a returned premium notice to the policyholder and/or payer, if different from the policyholder. On the following withdrawal date, any amount due will be withdrawn (unpaid premium and current premium).

4.16. Renewal

Renewal notice	If the premium amount has changed, a renewal notice is sent to the policyholder thirty-five (35) days prior to renewal. This notice includes a contract summary and a billing notice or payment plan update. A billing notice or payment plan is also sent to the payer if they differ from the policyholder. If the premium amount has not changed, no document is sent.
Special provision: Mortgage Plan	A renewal notice is sent ninety (90) days prior to the end of the term of the loan.
Monthly report on contracts to be renewed	A report indicating the contracts still in force but up for renewal the following month is available on your secured access of the Advisor resources page.

4.17. Tax receipt

Tax receipt	No later than February 28 of each year, the insurer automatically sends the payer of an accident and illness insurance policy a tax receipt for the portion of the premium eligible for the medical expenses tax deduction.

5. COMMISSIONS AND CONTRACTING

5.1. Service standards

Return of calls and reply to emails	Our target is to return calls and reply to emails within 1 business day.

5.2. Role of the Commissions and Contracting Department

The Commissions and Contracting Department is responsible for managing operations and contracts with our partners and Advisors.

The Commissions and Contracting Department:

- Creates advisor files
- Updates, terminates accounts
- Handles commissions and overdue accounts
- Follows up on the renewal of advisors' license
- Book of business transfer

To become a partner, to get more information, or to change your existing contract, contact the Commissions and Contracting Department. Refer to the "Contact Us" section.

You will be asked a series of questions each time you call to verify your identity and protect the confidentiality of our advisors' files.

5.3. Submitting a distribution request

5.3.1. Requirements

Required documents	• Copy of a valid license • Copy of liability insurance • A void cheque • Completed and signed Representative's Agreement • Representative Data Sheet • New insurance application • Quebec Enterprise Number (NEQ) when legal entity
Documents transmission	Documents must be sent through the file transmission form from the secure access on the Advisor resources web page.

5.4. Required certificates

To be able to sell our products, you must have the license required by your province and brokerage type.

Quebec brokerage firm	Valid "1a – Insurance of persons" certificate issued by Autorité des marchés financiers
Quebec independent advisor	Valid "1a – Insurance of persons" certificate issued by Autorité des marchés financiers
Ontario brokerage firm	Valid insurance agent license issued by the Financial Services Commission of Ontario
Ontario independent advisor	Valid insurance agent license issued by the Financial Services Commission of Ontario
Licences not accepted	Damage insurance licenses are not accepted

5.5. Liability insurance

Professional liability insurance	Proof of professional liability insurance coverage*. *This insurance grants advisors' coverage against the consequences of their civil liability in case of error, fault, negligence, or omission committed in the pursuit of their professional activities. Professional liability insurance is required because it protects both professionals and their clients.

5.6. Right of distribution renewal

Right of distribution renewal	The renewal of the right of distribution* is automatic. *A distributor who does not submit new business and has not had a policy in force for more than 12 months will be deactivated.
Valid licence	Hold and maintain a valid license and comply with the applicable laws of the province in which you wish to operate. Submit proof of the validity of the required licenses, certificates, and registrations annually*. *Failing to provide the required documents by the set deadline may delay the payment of your fees and the deactivation of the Info-Partners site.
Professional liability insurance	Hold and maintain valid liability insurance. Provide proof of the required professional insurance coverage on an annual basis*. *Failing to provide the required documents by the set deadline could delay the payment of your remuneration and the deactivation of the Info-Partners site.

5.7. Updating a file

Updating contact information	To change an address, telephone number, or email address, email a request to Commissions and Contracting.
Changing banking information	Send your request through the file transmission form from the secure access of the Advisor resources web page. Be sure to include: • Bank account change form duly completed and signed • A copy of a void cheque for the new bank account • Your distributor number

5.8. Tax statements

Eligibility	Only independent advisors that have been paid commissions during the year in question will receive a T4-A slip and/or RL-1 slip (Quebec). *The minimum threshold is $500.
Non-eligible	No T4-A or RL-1 slips are issued for: • Corporations • LLCs • Partnerships • Registered businesses (except in Quebec) • Advisors whose commissions are paid to a legal person that previously had a distribution agreement with or Ontario Blue Cross
Issuance	Receipts for the fiscal year in question are issued to the bank account owner no later than February 28, as required by law.

5.9. Account statements

Access to reports	Account statements are available on the Info-Partners.ca website. Records are kept for 18 months. Access to the "Reports" section is restricted to the person who holds an administrative code.
Commission rates	Commission rates are set out in your Distribution Agreement. Rates are based on the benefits sold, among other factors, and the percentage varies with the age of the contract.
Commission payment	Commissions are payable via direct deposit to a designated bank account. Amounts owing can be paid by credit card* within 60 days of the date of your account statements *Your credit card information must be given by telephone, via a secured line.
Frequency	• The weekly commissions statement period is from Sunday to Saturday • Commissions are paid the Monday after the end of the period, unless it is a holiday

6. CLAIMS – DISABILITY INSURANCE

6.1. Service standards

Processing time	Our target is to process at least 80% of all documents received within a maximum of 5 working days.

6.2. Documents to be sent through the file transmission form

Only original authorization requests should be sent directly to our offices.

Documents transmission	Documents must be sent through the file transmission form from the secure access on the Advisor resources web page.
By fax	1-877-590-7504

6.3. Initial claim for benefits

6.3.1. Submitting a claim

Notice and form	When an event occurs, it is important to notify the insurer as soon as possible to begin the claim process. On receipt of the notice, the insurer will send the "*Claimant's guide – Disability insurance*" containing all the forms needed to assess the insured's claim. The guide may also be downloaded from the insurer's website. On receipt of the completed ad signed forms, a claim file will be opened, and an acknowledgment of receipt will be sent to the insured.

6.3.2. Required documents

Required documents	The following forms must be sent to the insurer within the ninety (90) days of the onset of the disability: • Claimant's statement • Authorization forms (6) • Attending physician's statement • Employer's or self-employed worker's statement • Proof of Income, if required • Request for payment by direct deposit (optional)
Claimant's statement	This form includes three (3) sections: • **Insured's personal and medical condition**: If the claim is the result of an accident, it is important to provide information on the circumstances of the accident. • **Insured's training and occupational experience**: Answers making it possible to review opportunities for the insured to return to another occupation when they cannot resume their former duties. • **Insured's daily activities**: Answers making it possible to better understand the impact of the disability on the insured's self-care skill.
Authorization	Six (6) copies of the authorization forms must be signed and dated by the insured proving that they accept the disclosure of personal and medical information so that the insurer can start processing the claim. If the authorizations do not accompany the initial claim, it will be deemed incomplete.
Attending physician's statement	The attending physician's statement must include the following documents: • The standard form that must be completed and signed by the attending physician • A copy of the patient's medical record • A copy of the investigations made from the onset of the disability Note that the physician's fees to complete the form must be paid by the insured.

Employer's statement	This form must be completed by the employer if the insured is a salaried employee. If a job description is available, the employer must attach a copy to the form. Insured persons with more than one employer must have this form completed by each employer.
Self-employed worker's statement	This form must be completed by the insured if they are a self-employed worker or the sole shareholder of their company.
Proof of income	A disability benefit or monthly indemnity benefit aims to replace the insured's loss of income in the event of a disability. Income tax returns are therefore required to determine the pre-disability income. Proof of income does not need to be submitted at the time of the initial claim provided that: • Proof of income was submitted and accepted when the policy was issued (the insured must, if applicable, justify increases in the amount insured after issuance of the contract). • The amount insured is $1,000 per month or less for the first twenty-four (24) months, if the insurance application has been signed before June 1st, 2016. • The amount insured is $1,200 per month or less for the first thirty-six (36) months, if the insurance application has been signed after June 1st, 2016. • The insured is a member of an association and it has been agreed that the payable benefit is to be determined based on the number of beneficiaries under their care. The insured must produce official government documentation supporting this. • The claim for benefits is related to a mortgage. A copy of the most recent statements indicating the payments made and the balance of the mortgage loan or line of credit must be attached to the claim. • The claim is for a waiver of premium. • The claim is for the Overhead Expenses benefit. In all other cases, the insurer reserves the right to require proof of income based on the status of the insured.
Salaried employee	• Pages 1 to 4 of the federal income tax return (and provincial return for residents of Quebec) for the last calendar year preceding the disability or the best three (3) of the five (5) years preceding the disability • Notices of assessment received from the federal and provincial governments for the last calendar year preceding the disability or the best three (3) of the five (5) years preceding the disability
Self-employed worker	• Pages 1 to 4 of the federal income tax return (and provincial return for residents of Quebec) for the last calendar year preceding the disability or the best three (3) of the five (5) years preceding the disability • Notices of assessment received from the federal and provincial governments for the last calendar year preceding the disability or the best three (3) of the five (5) years preceding the disability • Copy of Form T2125 (Statement of business or professional activities), which was attached to the federal income tax return

Shareholder	• Pages 1 to 4 of the federal income tax return (and provincial return for residents of Quebec) for the last calendar year preceding the disability or the best three (3) of the five (5) years preceding the disability • Notices of assessment received from the federal and provincial governments for the last calendar year preceding the disability or the best three (3) of the five (5) years preceding the disability • The company's financial statements • Schedule 50 from the company's federal income tax return for the last fiscal year

6.3.3. Initial decision

Initial decision	Once the claim has been reviewed by the Claims Department, the insured will be informed in writing of the initial decision, i.e., acceptance, denial, or further investigation. If any other documents are needed to process the claim, the insured will be notified. Note that a copy of any correspondence is forwarded to the advisor (without confidential information). The only way for the advisor to know what information has been removed from their copy is to contact the client directly. The insurer will not be able to share this information with the advisor at any time.

6.4. File analysis

Telephone contact	During the process, as needed, the analyst will call the insured to collect or validate information and explain the status of the file. Note that telephone conversations may be recorded for training and quality control purposes.
Medical record request	In some cases, the analyst will request a complete copy of an insured's medical record. This information is needed for the insurer to properly determine the validity of a claim.
In-person interview	A meeting may be necessary to clarify the context of a claim. The insurer will use the services of agents trained in this regard or rehabilitation professionals.
Independent medical evaluation	The insurer may request, at its expense, that the insured be evaluated by a medical specialist of its choice. This evaluation is done by an independent physician who is not employed by the insurer. Refusal to undergo a medical evaluation may result in termination of benefits. The insurer uses this evaluation to provide the attending physician with a specialist's opinion and treatment options. A copy of the medical expert's report is sent to the attending physician, who may, at their discretion, comment on the expert's report. Insured persons who want to obtain a copy of the specialist's report will be invited to request a copy from their attending physician, who will be able to explain the content to them.
Rehabilitation services	Services not covered by the insurer's disability benefits may sometimes be provided at the insurer's expense with a view to facilitating recovery and an active life.

6.5. Benefits

6.5.1. Payment of benefits

Payment of benefits	Monthly benefits are payable at the end of each month following the end of the waiting period, provided that the insurer accepts the disability. Refer to the "Waiting Period" section. Payments—except for the first and last—normally cover a full calendar month. They are generally issued on the second Friday of each month to be mailed the following week. Regardless of the benefit payment method, a benefit statement will be systematically sent to the insured, except in the case of mortgage insurance. Note that the payment of benefits may be delayed if the insurer has requested additional information but has not yet received it. **Direct deposit** The insured can decide to have disability benefit payments deposited directly into their bank account. The insurer recommends this payment method, which allows the insured to use the funds as soon as they are transferred. Refer to the form included in the "*Claimant's guide – Disability insurance*". For claims related to loan payments, payments can be made directly to the insured, if the insured purchased mortgage insurance after February 1st, 2018. For all other cases, direct deposit is not offered and payments are made directly to the creditor. Note that direct deposit is not available if the claim concerns a request for a premium waiver.

6.5.2. Indexation of benefits

Indexation of benefits (optional clause)	If the insured choses this option during the application process, the insurer will index the benefits paid on the first (1st) of January of the year that follows the end of the first twelve (12) months of benefits. Indexation is generally based on the consumer price index (CPI) published by Statistic Canada. Some of the insurer's old contracts use the rate published by the Canada Pension Plan (CPP) or the Régie des rentes du Quebec (RRQ) instead. The applicable rate is stipulated in the insurance contract.

6.6. Reviewing new facts following a decision

Contesting the decision	If the insured wishes to contest our decision, they may submit new information at the following address: **Mailing address** Blue Cross Canassurance Life and Disability Claims Management 1981 McGill College Avenue, Suite 105 Montreal, QC H3A 0H6 The information may also be sent through our file transmission form on our website.

6.7. Contract clauses

Contract clauses	To make sure that the insured understands the extent of their coverage, it is important to explain the scope of certain contract clauses. The following clauses are especially important.

6.7.1. Date of disability

Date of disability	The date of disability corresponds to the first full day of total disability. It must be after the last day worked. For the purposes of the insurance policy, the date of the first medical consultation after stopping work is generally the first day of disability. The waiting period provided for in the policy is calculated based on this date.

6.7.2. Waiting period

Waiting period	The waiting period refers to the total disability period in which no benefit is payable. This period is indicated in the summary of benefits for the disability coverage or is specified in the policy wording on premium waivers. The waiting period is an uninterrupted period of total disability, but some policies allow more than one total disability period to be combined to meet waiting period requirements. Details will be provided in the policy.

6.7.3. Eligibility and exclusion clauses

Proof of disability	The existence of a medical condition or a diagnosis does not in itself constitute proof of the insured's inability to work. Disability is determined based on two factors: • The insured's temporary or permanent incapacity due to illness or accident. • The requirements of their job during tenure of the job or subsequently of any gainful employment consistent with their training, education, and experience. To better understand the impact of the medical condition on the insured, the insurer may regularly request additional medical information or information on the insured's duties.
Impaired driving	Policies provide for an exclusion in the case of impaired driving. When a claim is filed after a traffic accident, the insurer must obtain complete medical records to verify the exclusion.
Pre-existing conditions	Insurance policies issued without a prior medical examination carry exclusions for pre-existing conditions. A pre-existing condition is a medical condition (diagnosed or undiagnosed) that the insured suffered from or showed symptoms of prior to the effective date of the policy. The insured will not be entitled to benefits if they have, in the twelve (12) months prior to the effective date of their policy, consulted a health professional, undergone examinations, or been prescribed any drugs or treatments for the condition. The pre-existing condition exclusion no longer applies if the policy has been in force for at least twelve (12) months depending on the type of contract. If the insured files a claim that starts during this exclusion period, their medical history will be verified. This may delay the decision because the insurer must contact the insured's previously consulted physicians. The insured will be notified if such a delay occurs.
Incontestability	Most insurance contracts are issued based on the medical information provided by the insured during the application process. If a disability occurs less than (2) years after the effective date of the contract, the insured's medical history will be verified to confirm the accuracy of the information provided. This may delay the decision because the insurer must contact the insured's previously consulted physicians. The insured will be notified if such a delay occurs.

6.7.4. Financial clauses

Cancellation of automatic increases	Insureds who selected this option will no longer be entitled to automatic increases during their disability. Automatic increases will stop while the initial claim for benefits is under review. Any overpaid premiums related to automatic increases during disability will subsequently be reimbursed to the insured.
Dividends	Dividends are not deemed to be insurable earned income. If a business owner is paid dividends instead of a salary, the insurer will consider the net profit of their company on a prorated basis according to the shares the insured holds to determine their earned income. Previous years are not taken into consideration.
Rental income	Rental property income is not deemed to be insurable earned income. The insurer will not take this income into consideration in applying benefit reduction and coordination clauses.
Waiver of premium	If a disability claim is filed, the insurer will automatically process the premium waiver for coverage including this benefit. However, if the policy does not include disability coverage, a specific premium waiver application must be submitted. The forms included in the "*Claimant's guide – Disability insurance*" may be used for this purpose.
Taxation of benefits	When the applicant has selected a taxable benefit in the application, the insurer deducts federal and provincial taxes directly from the monthly benefit. Tax receipts will be issued at the end of the year.

Integration and coordination of benefits	The initial benefit payable by the insurer cannot exceed 100% of the insured's personal after-tax net income (90% of their personal pre-tax income if the benefits are taxable). If the insured has multiple sources of disability benefits, the insurer may integrate and coordinate the benefits: • The benefits paid by public insurance plans will be subtracted directly from the benefit paid by the insurer. • The benefit will also be reduced if the insured's total disability benefit from both public and private plans exceeds 100% of their pre-disability net income. If the insured's benefit is taxable, this limit will be 90% of the pre-disability gross income. If the insured submitted proof of income with the application, this income will be used for calculation purposes. However, the insured may provide proof of their pre-disability income if this is to their advantage, but the benefit amount cannot exceed the insured amount. Note that any disability benefits paid to the insured's creditors, such as insurance on a mortgage or automobile loan, are not included in the calculation for the integration or coordination of benefits. The insured remains responsible for making regular payments to the creditors and must negotiate an arrangement with them to obtain reimbursement of benefits paid by the insurer. **Quebec Pension Plan (QPP) and Canada Pension Plan (CPP)** These plans provide for the payment of a pension in the event of severe and prolonged disability that prevents the insured from engaging in any gainful employment. Benefits paid by the QPP or CPP are deducted from the disability benefit. Please note, however, that the insurer only considers the amount originally granted by the QPP or CPP and that there is no integration of benefits for the children of a disabled contributor.
Waiver of premium	The insured must continue to pay premiums even if they file a claim or apply for a waiver with the insurer. Once a premium waiver is accepted, any overpaid premiums will be reimbursed. Some insurance benefits do not include a premium waiver clause and premiums will continue to be billed during the disability. Please note that the insurer does not deduct the premiums from the benefits payable to the insured.

6.7.5. Obtaining a copy of the file

Obtaining a copy of the file	The insured can obtain a copy of their file by sending a written request to the insurer. Handling charges and some restrictions may apply. The insurer sends the insured's attending physician a copy of the medical expert's report(s), which they require for analysis purposes. The insured can obtain a copy of the report(s) from their physician, who may, if they deem it appropriate, explain the content to the insured. Note that the insurer cannot send an insured's file to a financial advisor, even with a specific authorization from the insured, in accordance with the Act respecting the distribution of financial products and services: "*37. No information of a medical or lifestyle-related nature received from a client may be disclosed by an insurer to a firm offering both credit and insurance, even with the authorization of the client.*"

7. CLAIMS – LIFE INSURANCE

7.1. Service standards

Processing time	Our target is to process at least 80% of all documents received within a maximum of 5 working days.

7.2. Documents to be sent through the file transmission form

Only original authorization requests must be sent to our offices directly.

Documents transmission	Documents must be sent through the file transmission form from the secure access on the Advisor resources web page.
By fax	1-877-590-7504

7.3. Submitting a claim

Notices and forms	In the event of the death of the insured, it is important to notify the insurer as soon as possible to start the claims process. On receipt of the notice, the insurer will send the required form to the beneficiary or liquidator.
Claim period	The completed claim must be submitted to the insurer as soon as possible. If the beneficiary or liquidator is unable to provide all the documents when the claim is submitted, they must contact the insurer. Any claim for benefits submitted within three (3) years after an insured's death will be considered within the claim period and will be analyzed. Once the claim is received, an acknowledgement of receipt will be sent to the claimant.

7.3.1. Required documents

Required documents	The life insurance claim must be sent to the insurer. It consists of the following documents: • Claimant's statement • Authorization forms (original) • Statement of physician who certified the death • Death certificate If no beneficiary has been designated on the insurance policy, the claimant must also attach the documents below.
In Quebec (if no designated beneficiary)	• Copy of the last will, testamentary search certificates from the Chambre des Notaires and Barreau du Québec. • If there is no will, a copy of the marriage certificate will be required.
In Ontario (if no designated beneficiary)	• Copy of the last will and copy of the certificate of appointment of estate trustee with a will. OR • Certificate of appointment of estate trustee without a will.
Claimant's statement	This form must be completed and signed by each of the beneficiaries on the policy. If there is no beneficiary, the benefit is part of the insured's succession and the form must be completed and signed: • In Quebec: By the executor • In Ontario: By the estate trustee
Authorization forms	The authorization forms must be signed and dated by the beneficiary, executor or estate trustee to start processing the claim. Any claim without authorization forms duly dated and signed will be considered incomplete and this will entail a delay in the claim process.
Statement of physician	This form must be completed and signed by the physician who certified the death. Note that the physician's fees to complete the form are covered by the beneficiary, executor or estate trustee.
Death certificate	Original documents are required but may—on request—be returned to the claimant depending on the amount of the benefit.

Required documents table (according to the policy Age and benefit amount)

Term of coverage in force	Less than 2 years (contestable period)	2–5 years	More than 5 years
Claimant's statement	X	X	X
Death certificate	X	X	X
Authorization forms (original copies only)	X	-	-
Search certificate from the Barreau du Québec	X	X (if more than $50,000)	X (if more than $50,000)
Search certificate from the Chambre des Notaires	X	X (if more than $50,000)	X (if more than $50,000)
Will (if applicable)	X	X (if more than $50,000)	X (if more than $50,000)
Statement of attending physician	X	x	X (if more than $50,000)

7.3.2. Decision of the Insurer

Communication of the decision	Once the claim has been analyzed by the Claims Department, the claimant will be informed in writing of the initial decision, i.e., acceptance, denial, or further investigation. Note that a copy of any correspondence will be forwarded to the advisor (without confidential information). The insurer will not be able to share this information with the advisor at any time.

7.4. Payment of life insurance benefit

Multiple beneficiaries	If the insured has not indicated a specific distribution of the benefit amount among the various beneficiaries, the benefit will be divided equally among all beneficiaries.
Interest	Interest is paid on any benefit paid more than thirty (30) days after the date of death. Statements for tax purposes are issued when the interest amount is $50 or more.
Taxation of benefits	Life insurance benefits are not taxable.
Direct deposit	Note that direct deposit is not available for the payment of life insurance benefits. A cheque will be issued to the beneficiary or beneficiaries.

7.5. Review of new information following a decision

Contesting the decision	If the insured wishes to contest our decision, they may submit new information to the following address: **Mailing address** Blue Cross Canassurance Claims Management 1981 McGill College Avenue, Suite 105 Montreal, QC H3A 0H6 The information may also be sent through our file transmission form on our website.

7.6. Contract clauses: Eligibility and exclusion

To ensure that the insured understands the restrictions and exclusions of coverage, it is important to explain the scope of certain contract clauses.

The following clauses are especially important.

Pre-existing conditions	Insurance contracts issued without a prior medical examination carry exclusions for pre-existing conditions. A pre-existing condition is a medical condition (diagnosed or undiagnosed) that the insured suffered or showed symptoms of prior to the effective date of the policy. A life insurance benefit cannot be paid if, the deceased insured had, in the twelve (12) months preceding the effective date of the policy, consulted a health professional, undergone examinations, or been prescribed any drugs or treatments for the condition resulting in the death. This exclusion no longer applies if the policy has been in force for at least twelve (12) months depending on the type of contract. If a claim is submitted within the exclusion period, the claimant's medical history will be verified. This may delay the decision since the insurer must contact the insured's previously consulted physicians. Note that the claimant will be informed if such delay occurs.
Incontestability	Most insurance contracts are issued based on medical information provided by the insured during the application process. If a death or disability occurs less than two (2) years after the effective date of the contract, the claimant's medical history will be verified to confirm the accuracy of the information provided. This may delay the decision, since the insurer must contact the insured's previously consulted physicians. Note that the claimant will be informed if such a delay occurs.
Impaired driving	Contracts provide for an exclusion in the case of impaired driving. When a claim is filed after a traffic accident, the insurer must obtain complete medical records to verify the exclusion.
Suicide clause	When a death results from a suicide that occurred within the first twenty-four (24) months or twelve (12) months depending on the product of the effective date of the life benefit, the benefit is not payable, regardless if the insured is of sound mind or not.

7.7. Obtaining a copy of the file

Obtaining a copy of the file	The beneficiary or liquidator can obtain a copy of the file by sending a written request to the insurer. Handling charges and some restrictions may apply. Note that the insurer cannot send an insured's file to a financial advisor, even with a specific authorization from the insured, in accordance with the Act respecting the distribution of financial products and services: *"37. No information of a medical or lifestyle-related nature received from a client may be disclosed by an insurer to a firm offering both credit and insurance, even with the authorization of the client."*

8. CLAIMS – HEALTH/DENTAL

8.1. Service standards

Processing time	Our target is to process at least 80% of all documents received within a maximum of 5 working days.

8.2. Documents to be sent through the file transmission form

Documents transmission	All documents related to a claim can be sent through the file transmission form. However, some documents, such as authorization forms to be sent to hospitals or the Ministry of Health, may require an original signature.

8.3. Extended Health Care benefit

Fees covered by Extended Health Care	• Hospitalization expenses • Services provided by health professionals such as psychologists, chiropractors, physiotherapists, podiatrists, etc. • Medical examinations, laboratory analyses, medical supplies • At-home nursing care • Cost of buying or renting certain medical devices • Wheelchairs • Eyeglasses and contact lenses • Prescription drugs (optional coverage) It is very important to refer to the contract for the details of the coverage as it may be different from one product to another.
Required information on submitted receipts	Receipts must include the letterhead of the person or company that provided the service and clearly indicate the following: • Patient's name • Service date(s) • Service description • Cost of each service rendered • Healthcare professional's name • Type of healthcare professional • Healthcare professional's licence or registration number

Restrictions	**Pre-existing condition** Any pre-existing condition may be excluded depending on the contract terms. **Exclusion specific to the insured** If the contract specifies an exclusion specific to the insured, the expenses for that exclusion are not eligible. Any pre-existing condition may be excluded depending on the contract terms. It is critical that any suspected or diagnosed conditions are fully disclosed at the time of application, otherwise the contract could be cancelled as of its issue date for a claim that was otherwise valid. **Massage therapy expenses** To be reimbursable, a signed doctor's prescription is always required and must be renewed annually. **Medical care** To be reimbursable, eligible medical expenses must be considered medically necessary. **Claim deadline** Claims must be submitted within 12 months of the service date.

8.4. Dental Care insurance

Coverage	Depending on the product and the text of the contract, eligible expenses are reimbursed according to: • The fees of the provincial dental association mentioned in the policy. • The previous year's guide for the year of services rendered or the current year's guide.
Treatment plan	For any treatment of $500 or more, the insured must send us a treatment plan that will be subject to the insurer's approval. As soon as the treatment plan has been analyzed, we will send a communication to the insured indicating the amount that will be payable.
Restrictions	Eligible expenses are reimbursable up to the maximum amount provided for in the contract. Orthodontic costs are not covered. It is very important to refer to the policy for the details of the coverage as it can be different from one product to another.