your group benefits

Contract Number: 101397 and 150897
Effective: July 1, 2018
Issued: October 12, 2018

Bimbo Canada

Retirees appointed to management before January 1, 1997 and who retired on or after January 1, 1997

BIMBO CANADA

Sun Life Financial

Table of Contents

How to Connect with Sun Life Financial

Questions?

We're here to help. Talk to a Sun Life Financial Customer Care representative for assistance with your coverage by calling toll-free at 1-866-881-0583.

For faster service, have your **group contract number** and **member ID** ready to enter into our automated telephone system.

Plan Member Services

Download the my Sun Life Mobile App!

- Free from the Apple App Store or Google Play, anytime
- Fast and easy access, wherever you go, to your benefit information
- View and/or submit mobile claims instantly, depending on your plan

Don't have a smartphone? Visit www.mysunlife.ca to obtain the following services:

- benefit information about coverage, claim status, and easy access to claim forms and/or e-claims, depending on your plan
- chat live with an agent
- send a secure email message to the Sun Life Financial Customer Care Centre
- contact information

Access to mysunlife website

The first time you access your group benefits online, you will need to register to get your personal access ID and password. To register you will need your group contract number and member ID.

All other inquiries

Call 1-877-SUN-LIFE (1-866-881-0583).

Benefit Summary

This is a summary of the coverage your plan provides. You should read it together with the information in the rest of this booklet. Please see the related sections of this booklet for more information, including exclusions, limitations and other conditions that apply to your plan.

General Information

We, our and us	Throughout this booklet, *we, our* and *us* mean Sun Life Assurance Company of Canada
Termination	Termination of coverage may vary from benefit to benefit as indicated in this Benefit Summary. Coverage may also end on an earlier date, as specified in the *General Information* section of this booklet.

Extended Health Care - Contract Number 150897

	Limited plan	Balanced plan
Benefit year	July 1 to June 30	
Deductible	None	None
Reimbursement level	For all eligible expenses, the reimbursement percentages are described below. However, for Prescription drugs, the reimbursement percentages described below apply to the first $1,000 of expenses per person per benefit year for associates and children, and the first $2,000 of expenses for spouses per benefit year, Thereafter, any eligible expenses in excess of $1,000 (associates and children) and $2,000 (spouses) per person per benefit year are paid at 100%.	For all eligible expenses, the reimbursement percentages are described below. However, for Prescription drugs, the reimbursement percentages described below apply to the first $1,200 of expenses per person per benefit year. Thereafter, any eligible expenses in excess of $1,200 per person per benefit year are paid at 100%.
Prescription drugs	80% - associates and children 75% - spouses	80%
	For associates residing in Québec, the reimbursement percentage is increased to 100% for drugs listed in the Régie de l'assurance-maladie du Québec (RAMQ) drug formulary once the out-of-pocket maximum has been reached Drugs covered under this plan must have a Drug Identification Number (DIN) and be approved under *Drug evaluation* We will cover the following drugs and supplies that are prescribed by a doctor or dentist and are obtained from a pharmacist: • drugs and oral contraceptives that legally require a prescription • life-sustaining drugs that may not legally require a prescription	

	• intrauterine devices (IUDs), diaphragms, contraceptive patches and contraceptive delivery systems, up to a combined maximum of 2 items per person per benefit year and a maximum of $25 per item • diabetic supplies • colostomy supplies We will also cover products to help a person quit smoking that have a Drug Identification Number (DIN) and have been approved under *Drug evaluation*, or that have a Natural Product Number (NPN), up to the maximum set by the Régie de l'assurance-maladie du Québec (RAMQ), regardless of where the person lives, provided that they are prescribed by a doctor or dentist and obtained from a pharmacist	
	There are drugs and treatments that are not covered, even when prescribed. Please refer to the Extended Health Care section of this booklet for details.	
Québec drug insurance plan	Any conditions under this plan that do not meet the requirements under the Québec drug insurance plan are automatically adjusted to meet those requirements.	
In-province hospital	100% of the difference between the cost of a ward and a private room	100% of the difference between the cost of a ward and a private room
Medical services and equipment	80% - associates and children 60% - spouses	80%
Ambulance services	100%	100%
Paramedical services	***Psychologists or social workers:*** 50% up to a maximum of $60 per visits, $500 per person and $1,500 per family per benefit year	***Psychologists or social workers:*** 50% up to a maximum of $60 per visits, $500 per person and $1,500 per family per benefit year
	All other Specialist: 80% (60% for spouses) up to a combined maximum of $300 per person and $1,000 per family per benefit year for all the qualified paramedicals listed below:	***All other Specialist:*** 80% up to a combined maximum of $300 per person and $1,000 per family per benefit year for all the qualified paramedicals listed below:
	• massage therapists or orthotherapists, acupuncturists, dieticians and homeopaths are limited to $30 per visit • speech therapists and audiologist are limited to $45 per visit • physiotherapists and naturopaths are limited to $35 per visit • occupational therapists are limited to $50 per visit • osteopaths or osteopathic practitioners, and podiatrists or chiropodists, including x-ray examinations, are limited to $35 per visit • chiropractors are limited to $30 per visit, and a maximum of $45 per person per benefit year for x-ray examinations *Per visit maximum reimbursement is based on eligible amounts*	
Change in options	You can change your option during the *annual enrolment period* or within 31 days of a *life event change*. Proof of good health is not required.	

Life - Contract Number 101397

Employee Life

Amount	25% of the Life amount for which you were covered on the day preceding retirement, rounded to the next higher $1,000 Maximum – $600,000 Minimum – $3,000
Reduction	At retirement, coverage is reduced to a percentage of the amount in force during your first year of retirement minus $3,000. The percentage is determined based on your retirement anniversaries, as described below: • 1st anniversary amount reduced to 80% • 2nd anniversary amount reduced to 60% • 3rd anniversary amount reduced to 40% • 4th anniversary amount reduced to 20% • 5th anniversary amount reduced to $3,000

Making Claims

There are time limits for making claims. You can find more on these time limits in the following chart. **If you fail to meet these time limits, you may not be entitled to some or all benefit payments**.

To assess a claim, we may ask you to send us the following documents:

- medical records or reports
- proof of payment
- itemized bills
- prescriptions
- other information we need.

Proof of claim is at your expense.

Instructions and Time Limits for Sending Us Your Claims

Use this handy reminder to help you meet the time limits for sending in your claim.

Type of claim	Starting the claims process	Limits and special instructions
Extended Health Care	Ask Sun Life for the form to complete, or get the form on our website. You can also submit claims for some expenses electronically. For more information, ask Sun Life.	Up to the earlier of the following dates: • 365 days after the date the expense is incurred, or • 90 days after the end of your Extended Health Care coverage.
Life coverage	Ask Sun Life to provide the claim forms.	**If the claim is a result of a death:** We must receive the claim form as soon as possible after the death occurred.

General Information

The information in this associate benefits booklet is important to you. It provides the information you need about the group benefits available through your employer's group contract with Sun Life Assurance Company of Canada (*Sun Life*), a member of the Sun Life Financial group of companies.

This booklet is only a summary of your employer's group contract. If there are any discrepancies between the group contract and the information in this booklet, the group contract will take priority, to the extent permitted by law.

Your group benefits may be modified after the effective date of this booklet. We will notify you in writing of any changes to your group plan. Any such notices will become part of this group benefits booklet and you should keep them in a safe place together with this booklet.

Have questions? Need more information about your group benefits? Talk to Sun Life.

Your group benefits	The contract holder, Canada Bread Company Limited, self-insures the Extended Health Care benefit. This means Canada Bread Company Limited has the sole legal and financial liability for this benefit and funds the claims. Sun Life provides administrative services only (ASO) such as claims adjudication and claims processing. All other benefits are insured by Sun Life.
Who is eligible to receive benefits?	To be eligible for group benefits, you must reside in Canada and meet all the following conditions: • you must have been covered under your employer's group plan on the day preceding retirement. **Your dependents become eligible** for coverage on the later of the following dates: • on the date you become eligible for coverage, or • on the date they become your dependent.
Who qualifies as your dependent	Your dependent must be: • your spouse or your child, and • residing in Canada or the United States. **Your spouse** qualifies as your dependent if they are your spouse in one of the following ways: • by marriage. • under any other formal union recognized by law. • as your partner of the opposite sex or of the same sex who is living with you and has been living with you in a conjugal relationship for at least 12 months. There is no minimum cohabitation period if a child is born out of the relationship. • .Any separation of more than 3 months entails the loss of the designation of spouse. You can only cover one spouse at a time. **Your children and your spouse's children** (other than foster children) are eligible dependents if they are under age 21 and do not have a spouse. A child who is a full-time student under age 26 is also considered an eligible dependent as long as the child is dependent on you or your spouse for financial support and does not have a spouse.

	If a child becomes disabled before the maximum age and remains continuously disabled, we will continue coverage if they are not able to support themselves financially because of a disability and must rely on you financially. The exception is if they have a spouse. In these cases, you must inform Sun Life within 6 months of the date the child attains the maximum age for this plan. **Ask Sun Life for more on this.**
When coverage begins	Your coverage begins on the date you become eligible for coverage. A dependent's coverage begins **on the later of** the following dates: • the date your coverage begins. • the date you first have a dependent.
Changes affecting your coverage	For changes requested due to a *life event change*, the change in coverage is effective on the date the request is received but not before the actual date of the *life event change*.
Updating your records	To ensure that coverage is kept up-to-date, it is important that you report any of the following changes to Sun Life: • change of dependents. • change of name. • change of beneficiary.
Accessing your records	You may request copies of your records, including: • any written statements or other record about your health that you provided to Sun Life in applying for coverage. • one copy of the insured contract. We will not charge you for the first copy but we may charge a fee for further copies. Need a copy of a document? Contact one of the following: • our website at www.mysunlife.ca. • our Customer Care centre, toll-free at 1-866-881-0583. For a copy of your enrolment form or application for insurance, please contact your employer.
When coverage ends	Your coverage will end on the earlier of the following dates: • the end of the period for which premiums have been paid to Sun Life for your coverage. • the date the group contract or the benefit provision ends. A dependent's coverage terminates on the earlier of the following dates: • the date your coverage ends. • the date the dependent is no longer an eligible dependent. • the end of the period for which premiums have been paid for dependent coverage. The end of coverage may vary from benefit to benefit. For information about a specific benefit, please refer to the Benefit Summary section at the beginning of this booklet.

Legal actions for insured benefits

Limitation period for Ontario:

Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the *Limitations Act, 2002*.

Limitation period for any other province:

Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the *Insurance Act* or other applicable legislation of your province or territory.

Legal actions for self-insured benefits

Where the applicable legislation of your province or territory permits the use of a different limitation period, every action or proceeding for the recovery of money payable under the plan is absolutely barred unless it is commenced within one year of the date that we must receive your claim forms. Otherwise, every action or proceeding for the recovery of money payable under the plan must be commenced within the time set out in the applicable legislation of your province or territory.

Coordinating your benefits with another plan

If you or your dependents are covered for Extended Health Care or Dental Care under this plan and another plan, the maximum amount that you can receive from all plans is 100% of the total eligible expenses.

When you have more than one plan, insurance industry standards determine which plan you should claim expenses from first.

Please send in claims for you and your spouse in the following order:

- First, send in the claim to the plan where the person is covered as an associate. If the person is an associate under two plans, send the claim to the different plans in the following order:
  - to the plan where the person is covered as an active full-time associate.
  - then, to the plan where they are covered as an active part-time associate.
  - then, to the plan where they are covered as a retiree.
- Next, send the claim to the plan where the person is covered as a dependent.

Please send in claims for a child in the following order:

- First send in the claim to the plan where the child is covered as an associate.
- Then, to the plan where they are covered under a student health or dental plan through their educational institution.
- Then, to the plan of whichever parent has the earlier birth date (month and day) in the calendar year. For example, if your birthday is May 1 and your spouse's birthday is June 5, you must claim under your plan first.

When you send us a claim, you must tell us about all other equivalent coverage that you or your dependents have.

Medical examination

We may require that you or your dependent have a medical examination if you make a claim. We will pay for the examination. If the person fails or refuses to have an examination, we will not pay any benefits.

Recovering overpayments

If we have overpaid any amount of benefit, we have the right to recover this money. We will:

- ask you to reimburse us,
- deduct that amount from other benefit payments, or
- recover that amount by any other legal means available.

Assignments

For Life benefits – You may not assign any rights or interests to anyone.
For all other benefits – We reserve the right to deny your request for an assignment.

Definitions

Here are the definitions of some terms that appear in this associate booklet. Other definitions that describe specific benefits appear in the benefit sections.

Accident	An accident is a bodily injury that occurs solely as a direct result of a violent, sudden and unexpected action from an outside source.
Annual enrolment period	The annual enrolment period is July 1.
Doctor	A doctor is a physician or surgeon who is licensed to practice medicine where that practice is located.
Illness	An illness is a bodily injury, disease, mental infirmity or sickness. Any surgery needed to donate a body part to another person which causes total disability is an illness.
Life event change	Life event changes include: • marriage or any other formal union recognized by law, or common-law. • birth or adoption of a child. • divorce or legal separation. • loss of spouse's benefit coverage. • death of a dependent.

Extended Health Care

General description of the coverage

The contract holder has the sole legal and financial liability for this benefit. Sun Life only acts as administrator on behalf of the contract holder.

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

Extended Health Care coverage pays for eligible expenses that you incur while covered under this plan.

Eligible expenses mean expenses incurred for the services and supplies described below that are medically necessary for the treatment of an illness and do not exceed the reasonable and customary charges for the service or supply being claimed

Medically necessary means generally recognized by the Canadian medical profession as effective, appropriate and required for treating an illness according to Canadian medical standards.

Reasonable and customary charges mean:

- fees and prices normally charged in the regional area where the services or supplies are provided, and
- charges for services and supplies that represent reasonable treatment, considering the duration of services and how frequently services and supplies are provided.

To qualify for this coverage you must be entitled to benefits under a provincial medicare plan or federal government plan that provides similar benefits.

Claiming when the expense is incurred	You must claim an expense for the benefit year in which you incur the expense. You incur an expense on the date you receive the service or purchase or rent supplies. The benefit year is indicated in the Benefit Summary. See the table **Instructions and Time Limits for Sending Us Your Claims** at the beginning of this booklet for information about when and how to make a claim.
Reimbursement level	Claims will be paid up to the reimbursement level under this plan. **For each type of service listed below, the reimbursement level is indicated in the Benefit Summary.**

Prescription drugs

Prescription drugs	We will cover the cost of the drugs and supplies that are listed in the Benefit Summary.
Quantity limit	Payments for any single purchase are limited to quantities that can reasonably be used in a 3 month period.
What is not covered	We will not pay for the following, even when prescribed: • the cost of giving injections, serums and vaccines. • treatments for weight loss, including drugs, proteins and food or dietary supplements. • hair growth stimulants.

	• drugs for the treatment of infertility. • drugs for the treatment of sexual dysfunction. • vaccines. • drugs that are used for cosmetic purposes. • natural health products, whether or not they have a Natural Product Number (NPN), except otherwise provided under the list of eligible expenses specified in the Benefit Summary. • drugs and treatments, and any services and supplies relating to the administration of the drug and treatment, administered in a hospital, on an in-patient or out-patient basis, or in a government-funded clinic or treatment facility.
Drug evaluation	The following drugs will be evaluated and must be approved by us to be eligible for coverage: • drugs that receive Health Canada Notice of Compliance for an initial or a new indication on or after November 1, 2017. • drugs covered under this plan and subject to a significant increase in cost. Drug expenses are eligible for reimbursement only if incurred on or after the date of our approval. We will assess the eligibility of the drug based on factors such as: • comparative analysis of the drug cost and its clinical effectiveness. • recommendations by health technology assessment organizations and provinces. • availability of other drugs treating the same or similar condition(s). • plan sustainability.
Pharmaceutical services (rendered by pharmacists)	For associates residing in Québec, we will cover the pharmaceutical services that are covered under the Québec drug insurance plan and apply its requirements.
Out-of-pocket maximum	For associates residing in Québec, expenses incurred for prescription drugs and not reimbursed under this plan as a result of the application of the deductible or the reimbursement percentage are limited in each benefit year to the yearly maximum contribution set by the Régie de l'assurance-maladie du Québec (RAMQ). There is an out-of-pocket maximum for you, and another one for your spouse. Any drug expenses incurred for your children are part of the out-of-pocket maximum of the parent with the greater amount of expenses during the benefit year.
Persons age 65 or over residing in Québec	Unless you have indicated otherwise, once you reach age 65 you are automatically registered for the public prescription drug insurance plan of the Régie de l'assurance-maladie du Québec (RAMQ), which provides basic coverage for prescription drug costs. Given that after age 65 you continue to be eligible for a medical expense benefit under your group plan, you must make a decision in regards to your basic coverage since you can be covered by either the public plan or your group plan. If you opt for basic coverage under RAMQ's public prescription drug insurance plan, your group plan will then provide coverage that supplements RAMQ's basic coverage. This supplementary coverage does not replace RAMQ's basic coverage; it adds to it by covering, for example, drugs that are not reimbursed by the public plan or the portion of drug costs not reimbursed by the public plan. In this case, when you complete your tax return, be sure to indicate that you are registered for basic coverage under RAMQ's public plan. You will then have to pay the premium.

	On the other hand, if you opt to keep your basic coverage under your group plan, you will have to cancel your registration in the public plan by calling RAMQ or visiting one of its offices during business hours. But before you do, we recommend you contact your benefits administrator to clarify your situation. Unfortunately, we cannot change your file without confirmation from your benefits administrator.

Hospital expenses in your province

Hospital	We will cover the cost of room and board in a hospital in the province where you live, as indicated in the Benefit Summary. A hospital is a facility licensed to provide care and treatment for sick or injured patients, primarily while they are acutely ill. It must have facilities for diagnostic treatment and major surgery. Nursing care must be available 24 hours a day. It does not include a nursing home, rest home, home for the aged or chronically ill, sanatorium, convalescent hospital or a facility for treating alcohol or drug abuse or beds set aside for any of these purposes in a hospital.

Your medical services at a glance

Covered expenses	Details	Payment limits
Medical services and equipment		
Out-of-hospital private duty nurse	Must be medically necessary Must be for nursing care, and not for custodial care, and must be prescribed by a doctor The private duty nurse must be a nurse or nursing assistant who is licensed, certified or registered in the province where you live and who does not normally live with you The services of a registered nurse are eligible only when someone with lesser qualifications cannot perform the duties	$10,000 per person per benefit year
Ambulance	Transportation in a licensed ambulance that takes you to and from the nearest hospital that is able to provide the necessary medical services Must be medically necessary	

Covered expenses	Details	Payment limits
Air ambulance	Transportation in a licensed air ambulance that takes you to the nearest hospital that is able to provide the necessary medical services Must be medically necessary	
Diagnostic services	The following diagnostic services that you receive outside of a hospital, except where your provincial plan considers the expense to be an insured service: • laboratory tests when prescribed by a doctor • ultrasounds • medical imaging services, including MRIs and CT scans	
Dental services following an accident	Dental services, including braces and splints, to repair damage to natural teeth caused by an accidental blow to the mouth that occurs while you are covered You must receive these services within 12 months of the accident	We will only cover up to the fee stated in the *Dental Association Fee Guide* for a general practitioner in the province where the associate lives
Contact lenses or intraocular lenses	After cataract surgery	One lens per eye, per lifetime
Wigs	After chemotherapy	$150 per person, per lifetime
Equipment	Medically necessary equipment that meets your basic medical needs, that you rented (or purchased at our request) For equipment to be eligible, we may require a doctor's prescription If alternate equipment is available, eligible expenses are limited to the cost of the least expensive equipment that meets your basic medical needs	For wheelchairs, we only cover the cost of a manual wheelchair, except if your medical condition requires that you use an electric wheelchair
Casts, trusses, crutches, splints, braces, walkers, artificial eye or custom-made orthotics for shoes	Orthotics must be prescribed by a doctor, podiatrist or chiropodist	Combined maximum of $350 per person per benefit year
Breast prostheses	Required as a result of surgery	$125 per person in any 24 month period
Artificial limbs		
Stump socks		5 pairs per person per benefit year
Elastic support stockings, including pressure gradient hose	Must be prescribed by a doctor	2 pairs per person per benefit year

Covered expenses	Details	Payment limits
Custom-made orthopaedic shoes or modifications to orthopaedic shoes	Must be prescribed by a doctor, podiatrist or chiropodist	Limited to expenses over the first $50 incurred during each benefit year for a person under age 18 or the first $100 incurred during each benefit year for any other person. There is a limit of one pair of shoes and a maximum of $300 per person in a benefit year
Hearing aids		$500 per person in any 36 month period. Repairs are included in this maximum
Oxygen		
Continuous Glucose Monitor (CGM) receivers, transmitters or sensors	Only for persons diagnosed with Type 1 diabetes You must provide us with a doctor's note confirming the diagnosis	Combined maximum of $4,000 per person per benefit year
Insulin pumps	Must be prescribed by a doctor	
Paramedical services		
Paramedical practitioners listed in the Benefit Summary	The paramedical practitioners must be qualified	Up to the reimbursement level indicated in the Benefit Summary We will not pay for the cost of services rendered by a podiatrist in Ontario unless they are performed after the provincial medicare plan has paid its annual maximum benefit

Qualified means a person who is a member of the appropriate governing body established by the provincial government for their profession. In the absence of a governing body, the person must be an active member of an association approved by us.

Qualified paramedical practitioners must:

- belong to a regulatory body or in the absence of a regulatory body, belong to an association approved by us,
- be licensed or registered, as required by the applicable provincial regulatory body,
- have undergone appropriate training and obtained necessary credentials in support of the services or supplies rendered,
- maintain clinical records and files consistent with the reasonable practices and standards of others in their field or as may be required by a regulatory body or association,
- produce clinical records and files to us upon request and generally act in a manner that is responsive to inquiries from us, and
- not engage in administrative practices unacceptable to us.

This is not an exhaustive list of qualifications. We have the sole discretion to determine whether a paramedical practitioner is qualified to render a service or provide a supply. To the extent that the qualifications listed above apply to clinics, we have the sole discretion to determine whether a clinic is qualified such that claims for services or supplies rendered at that clinic are eligible for reimbursement under this plan.

When coverage ends

See the Benefit Summary at the beginning of this booklet to see when your coverage ends.

What is not covered

We will not pay for the costs of:

- services or supplies payable or available (regardless of any waiting list) under any government-sponsored plan or program, except as described below under *Integrating with government programs*.
- implanted prosthetic or medical devices (examples of these devices are gastric lap bands, breast implants, spinal implants and hip implants).
- equipment that we consider ineligible (examples of this equipment are orthopaedic mattresses, exercise equipment, air-conditioning or air-purifying equipment, whirlpools and humidifiers).
- services or supplies that are not usually provided to treat an illness, including experimental or investigational treatments as defined in the contract.
- services or supplies that do not qualify as medical expenses under the Income Tax Act (Canada).
- services or supplies for which no charge would have been made in the absence of this coverage.

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

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

Integrating this plan with government programs

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

The covered expense under this plan is the remaining portion of the expense that the government program does not pay or make available, regardless of:

- whether you have made an application to the government program,
- whether your being covered under this plan affects your ability to be eligible for or entitled to any benefits under the government program, or
- whether there are any waiting lists.

Life Coverage

General description of the coverage

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

See the Benefit Summary at the beginning of this booklet to see the amount of coverage and the date coverage ends.

See the table **Instructions and Time Limits for Sending Us Your Claims** at the beginning of this booklet for information about when and how to make a claim.

Who we will pay	If you die while covered, we will pay the full amount of your benefit to your last named beneficiary on file with us. If you have not named a beneficiary, we will pay the benefit amount to your estate. Anyone can be your beneficiary. You can change your beneficiary at any time, unless a law prevents you from doing so or you indicate that the beneficiary is not to be changed. **Fact** There are different rules for designating a minor beneficiary, please refer to your contract for specific information.

Converting Life coverage

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

The request must be made within 31 days that the Life coverage reduces or ends.

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

Respecting your privacy

Respecting your privacy is a priority for the Sun Life Financial group of companies. We keep in confidence personal information about you and the products and services you have with us to provide you with investment, retirement and insurance products and services to help you meet your lifetime financial objectives. To meet these objectives, we collect, use and disclose your personal information for purposes that include: underwriting; administration; claims adjudication; protecting against fraud, errors or misrepresentations; meeting legal, regulatory or contractual requirements; and we may tell you about other related products and services that we believe meet your changing needs. The only people who have access to your personal information are our employees, distribution partners such as advisors, and third-party service providers, along with our reinsurers. We will also provide access to anyone else you authorize. Sometimes, unless we are otherwise prohibited, these people may be in countries outside Canada, so your personal information may be subject to the laws of those countries. You can ask for the information in our files about you and, if necessary, ask us in writing to correct it. To find out more about our privacy practices, visit *www.sunlife.ca/privacy.*

You have a choice

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

About Sun Life Financial

A market leader in group benefits, Sun Life Financial serves more than one in six Canadians, in over 12,000 corporate, association, affinity and creditor groups across Canada.

Our Core values – integrity, service excellence, customer focus and building value – are at the heart of who we are and how we do business.

Sun Life Financial and its partners have operations in 22 key markets worldwide including Canada, the United States, the United Kingdom, Hong Kong, the Philippines, Japan, Indonesia, India, China and Bermuda.

Life's brighter under the sun

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Sun Life Financial