

Get experience on your side



Administration Guide

Group Benefits Program





A Message to Plan Administrators

Getting Started

Who Should Use This Guide	5
Coverage Records and Resources	5
Administration Forms	6
Claim Forms	7
Online Resources	7
Privacy Policy	8

Managing Employee Information

Adding New Employees	
Background Information	9
Step-by-Step Instructions	12
Changing Employees	
Background Information	13
Step-by-Step Instructions	14
Terminating Employees	
Background Information	15
Step-by-Step Instructions	16

Understanding Your Invoice

Frequently Asked Questions	17
Reading Your Invoice	18

Making and Submitting Claims

Frequently Asked Questions	21
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Please note that this is a generic guide that contains information and instructions for administering all benefits. Some sections of this guide may not be applicable to your plan. Please refer to your Benefits Booklet for coverage details.



A Message to Plan Administrators

As your company's Plan Administrator, you are responsible for advising us of any employee additions, changes or terminations and ensuring that your employees understand their coverage. It's an important job, and we appreciate the time, effort and dedication required.

We've prepared this Administration Guide to provide you with the background information and details you'll need to administer your group benefits program. It includes step-by-step instructions for managing and updating employee information, invoice details, as well as answers to frequently asked questions about making and submitting claims.

Here are some of the other ways we assist you in administering your plan.

One Point of Contact

A dedicated Client Service Representative has been assigned to your account, so that you have one point of contact for all of your group benefits questions and requests.

We Keep It Simple

We walk you through the steps involved in managing your group benefits plan and provide you with direct access to the tools you need to get the job done quickly and easily. You'll find a range of helpful resources on our website, including employee Benefits Booklets, administration and claim forms and answers to your administration questions. Employees can also register for our Plan Member site, where they can download claim forms and access online claims information.

Details Are Our Business

As experienced administrators, we take care of the record keeping requirements, so you won't have to. You can rely on us to maintain the privacy and integrity of your data.

We're Serious About Client Service

As part of our commitment to client service, you can count on us to be knowledgeable and responsive when assisting you with the day-to-day management of your plan.

Getting Started

Who Should Use This Guide

Along with step-by-step instructions on group insurance administration, this guide provides important details and background information to members of your organization who:

- take care of administrative details;
- keep records or pay invoices;
- manage human resource functions or payroll; and
- communicate with your employees about their insurance coverage.

Coverage Records and Resources

A variety of materials are involved in the administration of your group benefits program. While an initial supply of forms has been supplied, additional copies can be requested from your Client Service Representative or downloaded from our website at www.encon.ca.

Your Client Number

Your eight digit client number is your ENCON file number. Please use this number whenever you communicate with us about your plan. Your client number is not used by other companies or individuals, or in the claims process.

Certificates of Insurance

Your employees will receive Certificates of Insurance. These personalized certificates confirm an employee's specific benefits and indicate if dependent coverage is in force.

Benefits Booklets

Your Benefits Booklet provides an overview of your company's group benefits program and outlines the benefits available to your employees. We will provide you with copies to distribute to your employees.

As all employees may not be insured for every benefit referenced in your booklet, they should consult their Certificates of Insurance to confirm which benefits apply to them and their eligible dependents.

ENCON Benefits Card

If your plan includes health and dental care coverage, employees will receive ENCON Benefits Cards. These cards may be used for pay direct drug plans as well as reimbursement drug plans. In addition, many other health and dental care providers can submit claims electronically on behalf of employees.

Pay Direct Drug Plan – Employees should present their cards to the pharmacist, who will submit claims directly to the benefits provider. Employees will only pay the amount not covered by their plan.

Reimbursement Drug Plan – Employees should present their cards to the pharmacist, who will submit claims electronically to the benefits provider. Employees will pay the full amount at the time of sale and eligible expenses will be reimbursed.

Other Service Providers – The Benefits Card can also be used for other types of claims, such as dental, vision and paramedical claims. Service providers will require the name of the carrier and the employee's Identification Number. Employees should show their service provider their Benefits Card in case the provider can submit the claim electronically.

Emergency Travel Assistance – If your group has extended health care benefits, employees covered under the health benefit are typically covered for ETA benefits. The ETA policy and phone numbers are listed on the Benefits Card.

Employee Identification Number

Each employee will be given a unique ID number, which is printed on the front of the Benefits Card below his/her name. It starts with the letters, "EGI," and ends with -00. This ID number is all that is required when submitting a claim.

Dependents (if any) are listed on the back of the card; each dependent is assigned their own unique dependent code -01, -02, etc.

Administration Forms

Administration forms are used to enroll your employees in your group benefits program, to report changes or to apply for excess coverage. The most frequently used forms, which can be downloaded from our website, are as follows:

Enrollment/Change Form – This is used to enroll new employees in your plan. It also acts as a change form, which can be used to request or communicate changes.

Evidence of Insurability Form – This form is required to initiate the medical underwriting process.

Optional Benefits Enrollment Form – With this form, your employees can request or refuse supplementary Life Insurance and Accidental Death & Dismemberment (AD&D) coverage over and above the basic employee or dependent benefits provided by your group benefits program. A completed Evidence of Insurability Form must accompany all requests for Optional Life and Spousal Optional Life, but is not required when requesting Optional Accidental Death & Dismemberment coverage.

There are additional administration forms that may be required from time to time. For example, there is a specialized Evidence of Insurability Form for Late Applicants. Your Client Service Representative will provide these forms as the need arises.

Claim Forms

These forms are used when submitting claims to the benefits provider. Most forms can be downloaded from our website. A list of frequently asked claim questions is also available online; you may find these helpful when responding to employee questions.

Health and Dental Claim Forms – If your group has extended health or dental coverage, a supply of claim forms has been provided. Every reimbursement cheque issued to an employee will include a pre-printed form to be used for the next claim submission.

Life, AD&D, Disability and Critical Illness Claim Forms – Your Client Service Representative will provide you with the appropriate Life, AD&D, Weekly Indemnity, Long Term Disability or Critical Illness claim form at the time of claim.

Online Resources

With custom-made sections catering to either plan administrators or employees, our website is designed to help make the process of managing your group benefits program as easy as possible.

Once you have logged in, you can view or print your invoices and your Benefits Booklet and link to helpful benefit-related websites, such as Employment Insurance or your provincial health care plan. Along with FAQ's, news and a glossary of insurance-related terms, our Resource Centre also houses an online administration guide for your convenience.

Employees can also register and gain access to their Benefits Booklet, administration and claim forms and a link to online claims information. Here, they can review their claims history, find out when they are next eligible for benefits (i.e. their next dental recall visit), and sign up for Direct Deposit to have claim payments deposited directly into their bank accounts.

We encourage you to visit us online and take advantage of all the features www.encon.ca has to offer.

Privacy Policy

The confidentiality of client information is very important to us.

In the process of managing and providing your group benefits program, both ENCON Group Inc. and the insurers involved may request detailed personal information about your employees. In recognition of the federal government's *Personal Information Protection and Electronic Documents Act (PIPEDA)* and the sensitive nature of such information, we want to assure you that we value your privacy – that's why we've implemented a policy to protect it.

ENCON Group Inc. has adopted the *Canadian Life and Health Insurance Association (CLHIA) Right to Privacy Guidelines (1994)* to ensure any confidential information supplied by you and your employees is appropriately protected and that access to such information is controlled and/or restricted.

We strongly believe in and adhere to these guidelines, in their strictest sense, in every aspect of our relationship with you.

For more information, please contact your Client Service Representative or visit our website at www.encon.ca.



Managing Employee Information

Adding New Employees – Background Information

This section explains when an employee is eligible for coverage. It is important that you adhere to these reporting timelines to ensure that your employees are enrolled without late applicant medical requirements. Step-by-step enrollment instructions follow this section.

When can an employee join the plan?

All full-time employees are eligible to join your group benefits program; an employee must work a minimum of 20 hours per week to be considered full-time. Your eligibility criteria were established at the inception of your plan and are confirmed in the Schedule of Benefits section of your Benefits Booklet.

The waiting period is the period of time each new employee must work for your organization before becoming eligible to join your plan. The employee's eligibility date is the day following the end of the waiting period. Your waiting period was also established at the time you applied for the plan and is confirmed in your Benefits Booklet.

An employee should join your group benefits program once he/she has satisfied these eligibility requirements.

Are there any other eligibility requirements?

The employee must be actively at work on the date the benefits become effective. If the employee is not actively at work on the date the insurance would normally be effective, then the benefits will commence on the first day on which the employee is again actively at work.

In order to be eligible for Extended Health Care benefits, an employee must be covered by a provincial health care plan.

What if we want an employee to have benefits immediately?

When hiring new employees, the ability to offer benefit coverage immediately upon joining your company can be an important recruitment tool. While your policy does not contain a waiver of the waiting period provision, your request to waive the waiting period will be reviewed on a case-by-case basis.

Waiving the waiting period is an extra-contractual service that the insurer provides, hence the need for insurer review and approval. All requests to waive the waiting period must be submitted in writing prior to the employee's effective date of coverage. The requests should include the rationale behind the waiver, as well as the employee's Enrollment Form. Your Client Service Representative will confirm if the waiver will be approved.

If you find that your company has a particularly high incidence of requests to waive the waiting period, you may want to consider amending the waiting period for all new employees. Your Client Service Representative can provide further direction on this issue.

When is medical underwriting required?

Medical underwriting is required under the following circumstances:

- When the amount of coverage exceeds a non-evidence maximum. These amounts are shown in the Schedule of Benefits section of your Benefits Booklet.
- When an employee and/or dependent(s) are deemed late applicants. Employees who do not submit written request for benefits within 31 days of their eligibility date must be medically underwritten and approved before coverage can become effective.
- When Optional Life and/or Spousal Optional Life coverage is requested. All amounts of coverage must be medically underwritten and approved before these benefits can become effective.

What is “medical underwriting”?

Medical underwriting is required when an employee is eligible for coverage above a non-evidence maximum or when an employee or dependent is deemed a late applicant. The insurer will review the medical history of the applicant and, based on the health of the applicant, determine if coverage can be made available.

If an employee is being medically underwritten, the insurer may request additional lab tests, paramedical reports, and/or blood profiles. If the employee has applied for dependent coverage, dependents must also provide medical evidence to the insurer.

This process can take anywhere from four to six weeks, depending on the amount of coverage requested, the type of additional medical information required and how quickly that information is provided.

What is a “non-evidence maximum”?

A non-evidence maximum is the maximum amount of coverage an employee can receive without providing medical evidence. Based on the medical evidence provided by the applicant, an insurer can approve, decline or postpone coverage above the non-evidence maximum but cannot reduce the coverage already in force.

Non-evidence maximums, which are different from overall benefit maximums, will usually apply to life and disability benefits and are determined by the size of your group. The non-evidence and overall benefit maximums are shown in the Schedule of Benefits section of your Benefits Booklet.

What is a “late applicant”?

All employees must be enrolled within 31 days of their eligibility date. If enrollment material is not completed within this timeframe, the employee is considered a late applicant and will be required to provide medical evidence in order to obtain group insurance coverage.

Coverage for late applicants is not guaranteed, and will only go into effect when the insurer has reviewed and approved the application. The effective date will not be backdated.

Do all employees have to enroll in the plan?

There are contractual participation requirements that apply to your group benefits program. These requirements are based on the number of employees on staff and the employee premium contributions.

- If your organization pays 100% of the premium, all eligible employees must participate in your group benefits program.
- If your organization has 10 or more full-time employees who pay any portion of the premium, then only 75% of all eligible employees must participate in your plan. Consequently, an employee can choose to opt out of all benefits offered by your plan, provided that you continue to meet the 75% participation requirement. The employee must complete a Group Benefits Waiver Form and should understand that future enrollment in the plan will be subject to late applicant rules.
- Employees who are covered under a spouse's plan may only waive health and/or dental benefits; they must participate in all other benefits offered in your plan. This is discussed in further detail below.

Your group benefits program can be cancelled if these participation requirements are not satisfied. Accordingly, we recommend that you make enrollment in your plan a condition of employment for all new employees.

What if an employee is already covered through a spouse's group benefits program?

A spouse's group benefits program may provide your employee with health and/or dental coverage; it will not provide your employee with life or disability benefits. As a result, your employee may choose to waive the extended health and/or dental benefits portion of your coverage, but must participate in other benefits offered by your group benefits program.

Employees requesting a spousal coverage waiver should provide the spousal policy information on their Enrollment Form. Any loss of spousal coverage must be reported to your Client Service Representative within 31 days of losing that coverage or late applicant rules will apply to health and dental benefits for the employee and eligible dependent(s).

If your employee does not enroll in the life and/or disability portion of your plan and attempts to enroll in the future, the employee will be deemed a late applicant.

What is the Medical Information Bureau?

The Medical Information Bureau (MIB) is a non-profit membership organization of life insurance companies that operates as an information exchange for its members.

An insurance company or its reinsurers may periodically report information to the MIB. If an individual applies for life or health insurance coverage or if they submit a claim for benefits with another MIB member company, the MIB will, upon request, supply that company with the information on file.

An insurance company or its reinsurers may also release information to other life and health insurance companies to whom an individual may apply for insurance or submit a claim for benefits. All information obtained is treated as confidential between insurers and/or members of the MIB.

Upon an individual's request, the MIB will disclose information it has on file for that individual. If an individual questions the accuracy of information in the Bureau's file, he/she may contact the MIB and seek a correction.

Adding New Employees – Step-by-Step Instructions

Who Should be Enrolled

Employees who have been hired on a permanent, full-time basis and employees who move from part-time to full-time status should be enrolled in your group benefits program.

How to Enroll New Employees

1. Add your group's waiting period to the employee's date of hire to determine the eligibility date. Your waiting period is confirmed in your Benefits Booklet.
2. At the time of hire, or at least 31 days before the employee's eligibility date, have the employee complete the Enrollment Forms:
 - Enrollment/Change Form
 - Evidence of Insurability Form
 - Optional Benefits Enrollment Form
3. Ensure the forms are complete, correct and signed by the employee. Following your review of the information, sign the Employer Authorization section.
4. Submit the original forms to your Client Service Representative. Faxed copies of these forms cannot be processed.
5. Issue claim forms and a Benefits Booklet to the employee and advise that the Certificate of Insurance and Benefits Card(s) are forthcoming.
6. Review your next invoice to ensure the employee's name appears on the invoice and the information is correct.
7. If medical underwriting is required and a completed Evidence of Insurability Form has not been provided, we will request that a form be completed. The initial request for medical evidence will be sent to you to deliver to the employee; all future correspondence will be sent directly to the employee. As the employer, you will only receive notification of those decisions that will affect your monthly premium.

Changing Employees – Background Information

This section outlines how changes in an employee's personal situation or employment status can affect his/her benefit coverage. Requirements for reporting employee absences and dependent changes are also discussed. Step-by-step reporting instructions follow this section.

What kind of changes will affect benefit coverage?

The type of changes that can affect an employee's coverage include changes in:

- salary
- employment status or class
- number of hours worked
- coverage required (single or family)
- province of residence
- dependents or dependent status
- name
- spousal coverage with respect to waiver or co-ordination of benefits
- age

Are there changes that won't affect benefit coverage?

You do not have to notify us of employee sick days, vacation days, or transfers within the company, as they do not usually affect benefits.

If you are unsure if a specific change will affect an employee's coverage, you should contact your Client Service Representative for advice.

Why is it important to communicate dependent changes?

The benefits provider will only pay claims for those employees and dependents who are on record as eligible. This is known as positive enrollment. If a dependent is not listed on the employee's file, or if the information is incorrect (i.e., date of birth, gender, relationship), claim problems may occur. Your employees' coverage can be affected if we are not notified within 31 days of any dependent changes.

For example, when changing from single to family coverage (i.e., when adding the first dependent), employees must request dependent coverage within 31 days of obtaining the dependent through marriage, birth, adoption, etc. If the first dependent is not registered within 31 days, the dependent will be deemed a late applicant. Notification for the second, third or fourth dependent is not as time sensitive since the late applicant rules do not apply to subsequent dependents. However, claims cannot be paid until the dependent is enrolled.

What happens when employees have changes in salary and employment status?

All changes in an employee's salary or employment status should be communicated to ENCON promptly. If benefit levels are determined by salary, medical underwriting may be required.

When should ENCON be advised of an employee's absence because of sickness or injury?

The notification requirements will depend on the benefits included in your group program.

For example:

- If Weekly Indemnity is included in your group benefits program, you should advise us immediately if an employee is absent from work for two weeks or more as a result of injury or sickness.
- If Long Term Disability is included in your group benefits program, you should notify us when an employee has been absent for 90 days because of sickness or injury if you do not expect the employee to return to work within four months.
- If your group benefits program does not provide Weekly Indemnity or Long Term Disability benefits, you should notify us if it appears that an employee will be away for a prolonged period of time. Life Insurance and AD&D benefits both include Waiver of Premium provisions which may provide for the continuation of coverage without premium payment if the employee is deemed to be totally disabled.

Once we are notified of the absence, we will provide you with the necessary information as well as the forms you and your employee must complete to file the claim.

Does an employee's coverage continue during maternity and/or parental leave?

A combination of federal Employment Insurance legislation, provincial Employment Standards and Human Rights legislation govern benefit requirements for employees on maternity and/or parental leave. It is important that you are aware of the requirements in your province, since the continuation of benefits during a leave may or may not be required by law.

Benefit continuance during a leave is also contingent upon the employee's continued premium contributions. If an employee does not continue premium contributions during the maternity or parental leave, it will affect the employee's coverage both during the leave and upon return to active employment.

Contact your Client Service Representative for details on provincial legislation, direction or advice.

Changing Employees – Step-by-Step Instructions

When Changes Should Be Communicated

Any change that will affect an employee's eligibility or level of coverage should be reported to your Client Service Representative within 31 days of the change.

How to Change an Employee's Coverage

1. ENCON must be advised of all employee changes in writing. Send the change request to your Client Service Representative.
2. Most employee changes can be communicated by mail, fax or email. Remember, however, that an original employee signature is required on changes in beneficiary designations and on Evidence of Insurability forms.

3. Keep a copy of the change request for the employee's file. Depending on the nature of change, the employee may require a copy for their personal records as well.
4. Review your next invoice to ensure the change appears and the employee information is correct.
5. New Certificates of Insurance and/or Benefits Cards will be produced when there is a change in benefit coverage, benefit levels or dependent status.

Terminating Employees – Background Information

Employees who cease employment with your organization are no longer eligible for benefits and all coverage must terminate. Step-by-step termination instructions follow this section.

When does coverage end for terminated employees?

Benefits terminate on the employee's last day of active employment. Benefits do not continue until the end of the pay cycle or the end of the month. It is important that this is understood since claims incurred after the last day of active work will not be deemed eligible under the terms of the policy.

Can an employee's benefits be extended past termination?

If your organization wishes to extend an employee's benefits beyond the last day of active employment, a written request must be submitted prior to the employee's last day of work. Benefit extensions are granted on an extra-contractual basis and as such, must be approved.

The request should include the:

- employee's name and identification number;
- date of termination of employment;
- list of benefits to be extended and the proposed termination date of each benefit; and
- the reason for the request (i.e., as part of a severance package, recent lay off or due to length of service).

If benefits continue past the last day worked without approval, the employer may be held liable for any incurred claims.

Please note that the insurer will not extend Disability Benefits past the duration of the statutory notice period. Basic Life, AD&D, Extended Health and Dental coverage can be extended for longer periods, subject to approval.

What is the Life Insurance Conversion Privilege and how does it work?

At termination, employees have the right to convert their Life Insurance coverage to an individual policy without satisfying any medical evidence requirements. This is known as the Conversion Privilege. You should advise your employees of this privilege at termination.

The individual insurance must be applied for and the first premium paid within 31 days of termination. If an employee dies within this period, a death benefit equal to the maximum amount of Life Insurance the employee would have been eligible to convert will be paid to his or her beneficiary even though the Conversion Privilege may not have been exercised.

The maximum amount of insurance that can be converted, the plan options and the premium rates will be determined at the time of conversion. This privilege does not apply for loss of insurance at specified age reductions or at the maximum coverage age.

Your Client Service Representative can provide you with the appropriate forms, conversion rates and additional information as required. Life conversion forms are also available online at www.encon.ca.

Terminating Employees – Step-by-Step Instructions

When Coverage Should Be Terminated

Employees who no longer work with your company or no longer qualify for coverage under the eligibility terms of your policy must be terminated from your plan.

How to Terminate an Employee's Coverage

1. ENCON must be advised of the termination in writing. You should fax, mail or email the request to your Client Service Representative immediately so claims incurred after the termination date are not paid.
2. Advise the employee that coverage will terminate on their last day of active work. Coverage does not extend to the end of the pay cycle or to the end of the month.
3. Advise the employee of the Conversion Privilege (the right to convert the life insurance benefit) and that the Conversion Privilege must be exercised within 31 days of termination.
4. If you choose, collect and destroy the employee's Benefits Card.
5. Review your next invoice to ensure the employee has been terminated.

Note: If a termination is reported retroactively, it is our practice to check if any claims were incurred and paid after the requested termination date. If claims were paid, premium will be charged to the date the last claim was incurred.



Understanding Your Invoice

Along with premium and pay deduction information, your invoice provides detailed information about employee coverage and benefit levels. A sample invoice is included in this section.

Frequently Asked Questions

How are the premiums charged?

Enrollments, changes or terminations received in our office by the 15th day of the month will appear on the invoice generated on approximately the 20th of that month. Any change requests received after the 15th of the month will appear on the following month's invoice, along with any applicable premium adjustments.

Premium charges for additions, changes or terminations are not pro-rated. Adjustments are calculated if premium is effective on the first day of the month. When coverage is effective mid-month, premiums will not be charged for the partial month of coverage. However, if coverage terminates mid-month, premiums will be charged for the full month.

What are the terms and conditions of premium payment?

Your group insurance premium is due on the first of the month for the month during which coverage is in force. For example, your August premium is due on August 1st. A 30-day grace period is provided.

We value your business and want to ensure that your benefit coverage continues without interruption. If we have not received your premium payment by the 23rd of the month, we will forward a friendly reminder to your office before the grace period has expired.

Should premium payment not be received within the 30-day grace period, your group insurance will remain in force; however, claim payments will be suspended until your account is paid up to date. Claims incurred during the suspension period will be considered once the account is again in good standing. Any claims rejected during the suspension period must be re-submitted to the insurer for consideration.

If your account falls into arrears beyond 60 days, your policy will be terminated for non-payment of premiums.

How can premium be remitted?

Monthly premium payment can be made as follows:

- By automatic bank debit. You may sign up for this payment method at any time by providing a void cheque and written authorization to your Client Service Representative.

continues on page 20

Reading Your Invoice

The following outlines the standard information included in your invoices:

- A** Your company's name and mailing address.
- B** Your ENCON Client Number.
- C** The invoice month and due date.
- D** Your Client Service Representative's name and contact information.
- 1** In the DIV column, any pre-arranged divisions or classes will be shown. Employees covered under the plan will be listed by class, in alphabetical order by last name. The employee's identification number is listed beneath the employee's name.
- 2** The employee's effective date of coverage.
- 3** These columns list each benefit provided in the plan. For example, the BASIC LIFE column shows the volume (or amount) of Basic Life coverage each employee is insured for. The adjacent column may list the premium.
- 4** When two premium amounts are listed, the top number is the "current" monthly premium for that benefit. The bottom number is the "retroactive" or adjusted premium amount.
- 5** In the DEP. LIFE, MEDICAL and DENTAL columns, the invoice may list either a description of coverage (i.e., Single or Family) or a premium amount. If the column is blank, that employee is not insured for that coverage.

Other coverage information may appear within the coverage columns, such as:

- WP** This indicates that premium for a particular benefit has been waived due to disability.
- SURV** This indicates that survivor benefits are in force; premiums are waived.
- TERM** This will appear in the "Total" column if an employee's coverage has been terminated.
- WAITING** This indicates that the employee is still in the waiting period and benefits are not yet in force.
- PENDING** This indicates that coverage is pending, possibly because of medical underwriting or outstanding information.

A
 THE ABC COMPANY LTD.
 MK. HANK HEALTHY
 1900 - 161 BAY STREET
 EDMONTON AB T2T 2T2

B
 CLIENT#: 018-80199

05/17/02 PAGE 1

PERIOD: JUNE 2002

DIV.	EMPLOYER NAME EFF	EFF DATE	BASIC LIFE	BASIC ADAD	DEP. LIFE	L.T.D.	MEDICAL	DENTAL	PAY			
									DEBUC	TOTAL		
	BRIDGEWORK, BARRY 000-021-240	02-05-01	72000	8.64	72000	2.09	1500	6.90	SINGLE	SINGLE	39.35	71.77
	FLOSS, DEREK 000-021-238	02-06-01	75000	9.00	75000	2.18	1500	6.90	FAMILY	FAMILY	26.69	71.77
	HEALTHY, HANK 000-021-232	02-05-01	75000	9.00	75000	2.18	1500	6.90			83.18	159.44
	HEARTHEAT, HANNA 000-021-241	02-06-01	WP		WP	1.03	WP	6.90	FAMILY	FAMILY	13.01	19.11
	HOSPITAL, HOLLY 000-021-231	02-05-01	2.09								13.01	19.11
	MASSAGE, N 000-021-235	02-05-01	75000	9.00	75000	2.18	1500	6.90	WAITING	WAITING	70.17	140.33
	TOTAL CURR VOLUME		297000		297000	3 YES	6000	15 2P	15 2P			
	TOTAL ADJ VOLUME		172000		172000		4000					
	TOTAL CURR PREMIUM		35.64		8.63	3.09	27.60	158.69	176.11		218.72	
	TOTAL ADJ PREMIUM		19.55		2.18		6.90	39.31-	46.88-		29.33	
	TOTAL CURR NO. EES		4		4	3	4	3	3			
	* CURRENT CHARGES:	409.76		ADJUSTMENTS:	61.56						TOTAL:	350.88 *
	* ADMIN FEES:			2.50		GST:	.18					
	TOTAL NOW DUE:										350.88 *	

ENCON

THIS IS YOUR FILE COPY

PLEASE PAY INVOICE AS BILLED
 Any changes received in writing, by the Premium Due Date shown above, will be included in your next invoice.

- 6 This column shows the employee's monthly premium contribution.
- 7 This is the total monthly premium for each employee. This amount includes the employee's contribution.
- 8 The total amount of insurance and the number of employees covered for each benefit as well as the current and adjusted premium for each benefit are summarized in these five rows.
- 9 The total current premium, total adjusted premium and the total premium due are shown. Any outstanding premium will be listed directly below the current charges, by month and invoice number. If you pay your invoice by automatic bank debit, the debit amount to be withdrawn on the first banking day of the month is listed; the amount owing will always appear as \$0.

Frequently Asked Questions *(continued from page 17)*

- By cheque or money order, made payable to ENCON Group Inc. Please include your eight digit Client Number on your cheque.
- By banking online. When adding ENCON Group Inc. as a new payee, use your eight digit Client Number as your account number.
- By wire transfer. Your Client Service Representative can provide you with the details.

Our preferred method of premium collection is automatic bank debit. Should you choose an alternate method, a \$10 monthly administration fee will be charged. This fee will be waived if your monthly premium is in excess of \$750.

A \$25 service charge will be applied to each instance of a refused bank debit or NSF cheque.

How do I know what to charge the employee as a pay deduction?

The employee contribution is the amount of premium an employee must pay toward his/her benefit coverage. The contribution amount was determined at the inception of your plan.

Your invoice includes a pay deduction column, which confirms the total monthly premium amount that each employee is responsible to contribute. If the column is blank, no pay deduction is required.

Optional Life, Spousal Optional Life and Optional Accidental Death & Dismemberment are all employee paid benefits. The full cost of these benefits should be deducted from the employee.

Why are the pay deductions and contributions so important?

It is important that your payroll records accurately reflect the employee and employer contributions as these can affect an employee's taxable income and the taxability of any benefits received.

If an employer pays any part of the Basic and/or Dependent Life premiums on behalf of an employee, the paid premium amount and applicable sales tax is considered taxable income and must be reflected on the employee's T4.

In Quebec, any employer paid portion of Basic Life, Dependent Life, Accidental Death & Dismemberment, Extended Health Care and Dental Care premium as well as the applicable sales tax must be included as taxable income to the employee.

The taxable status of an employee's disability benefit is also affected by premium payment. If an employer pays any portion of the Weekly Indemnity and/or Long Term Disability premiums on behalf of an employee, any Weekly Indemnity and/or Long Term Disability benefits received by that employee are taxable under both the Federal and Quebec Income Tax Acts. In order for these benefits to be non-taxable, the employee must pay the entire cost of the benefit.

If you have any questions about your premium or invoice, please contact your Client Service Representative for assistance.



Making and Submitting Claims

Frequently Asked Questions

As the Plan Administrator, you often act as the first point of reference for your employee's benefit questions. The information below will help you respond to some of these common questions. You may also reference our website at www.encon.ca for additional FAQ's.

How is a Life or AD&D claim submitted?

In order to initiate a Life or AD&D claim, contact your Client Service Representative who will provide the claim forms, confirm beneficiary and benefit amounts and provide further instructions. The claim forms will be sent to you immediately and depending on the nature of the claim, you may need to co-ordinate information from the beneficiary, the employee, the employer and possibly the attending physician.

The completed claim forms and supporting documentation should be collected and forwarded to your Client Service Representative, who will then submit the claim to the insurer(s).

How is a Weekly Indemnity or Long Term Disability claim submitted?

You should advise your Client Service Representative of an employee's absence and pending disability claim as soon as possible so the appropriate claim form can be sent to you immediately.

The Disability claim form has sections for the employer, employee and the employee's attending physician to complete. The claim form and any supporting documentation should be forwarded to your Client Service Representative who will submit the claim to the insurer on your employee's behalf. The employee and the employee's physician can elect to send personal information directly to ENCON.

Because these benefits are "salary replacement" benefits, it is important to initiate the process as soon as the claim is known. It is equally important that you advise your Client Service Representative when an employee returns to work to avoid any benefit overpayment.

How should health and dental claims be submitted?

Employees should show their Benefits Card to their service provider in the event the claim can be submitted electronically. If not, a claim form should be completed and submitted, with the proper documentation, to the address provided on the form.

Claims should be submitted within the calendar year. If either an employee or the plan is terminated, eligible claims must be submitted no later than 30 days after the termination date.

My employee's health or dental claim was declined. How can the employee find out why?

If an employee asks you for assistance with a declined claim, advise him/her to review the returned claim documentation. Claim reimbursement cheques are accompanied by an Explanation of Benefits (EOB) that explains why certain expenses are excluded or advises if additional information is required before the claim can be considered. You can also direct the employee to the Benefits Booklet or to www.encon.ca to determine if the claim submitted is an eligible expense under your plan.

If the employee did not complete the claim form correctly or did not provide required information, the claim will be returned with instructions for revision and resubmission. The employee should review the claim form to ensure that all the information requested in each section of the form has been provided. If the claim is for a dependent, the claim may be returned if the dependent has not been registered.

Privacy guidelines restrict the type and amount of information an employer or plan administrator can access. While we cannot release information about an employee's claim to a person other than the employee without the employee's written consent, you may still contact your Client Service Representative for assistance. We will investigate the issue on your behalf. Also, your employees can research a claim payment or status by contacting the benefits provider directly or by registering for online claims access at www.encon.ca.

If a child is away at school, does coverage continue under the plan?

Dependent children are eligible for extended health and dental care up to the age of 22, provided they continue to be dependent. A child is no longer eligible for coverage when he/she is working full-time. If the dependent is more than 22 years old and in full-time attendance at college or university, coverage can continue until the age of 25 if written proof of student status is provided. A copy of the child's student card, school registration or letter is sufficient proof.

With proof of student status, dependent coverage will continue until the following September, at which point the extended coverage will automatically expire. Should the child return to school in September, updated proof of student status must be provided to further extend coverage.

In Quebec, for drugs covered under RAMQ, a child is considered a dependent if in full-time attendance at an accredited school, college or university until age 26.

What protection is offered while travelling out of province or out of country?

Emergency Travel Assistance (ETA) is typically included as part of the health care coverage. Your Benefits Booklet will confirm if ETA benefits are offered as part of your group benefits program. If your plan includes ETA, employees must be enrolled in Extended Health Care to be eligible for this coverage.

Depending on the destination, your employee may be advised to contact the ETA provider prior to departure. Advice or assistance in preparing for their trip can be provided as can a current list of known countries where providing emergency medical assistance may be a problem. Employees can call the ETA number listed on their Benefits Card.

What's involved in using ETA services while travelling?

If an employee or covered dependent has a medical emergency while they are travelling out of province or out of country, they must contact the Emergency Travel Assistance provider within 48 hours of the commencement of treatment. The travel assistance provider should be contacted at the time of claim so they can co-ordinate benefits between the employee's provincial and group benefits programs.

Covered dependents travelling without the insured employee are also covered for ETA services.

How is an emergency travel claim submitted?

For emergency services of \$200 or less, the employee should pay the service provider, obtain a fully itemized invoice and submit the claim upon returning home. Receipts are first submitted to the provincial health care plan for reimbursement. Any amounts that the provincial plan has not reimbursed should then be submitted to the carrier for consideration. Employees should keep copies of these claim submissions.

If it appears that the cost of the claim will exceed \$200, the employee should contact the ETA provider immediately. This allows the provider the opportunity to assess the situation and provide the employee with personal assistance during the emergency.

What is "co-ordination of benefits"?

In cases where an employee and his/her dependents are eligible for coverage under more than one insurance plan, the co-ordination of benefits provision allows one claim to be submitted to multiple carriers. By co-ordinating the benefits offered through each plan, the employee can be reimbursed for up to 100% of the total expense. If both spouses wish to co-ordinate benefits, both spouses must have family coverage.

How is a co-ordination of benefits claim submitted?

The insurance industry has created standard submission guidelines for co-ordination of benefit claims. These rules establish which plan is responsible for making the initial claim payment and which plan receives the balance of the expense.

The claimant determines which plan is the first payer. For example, when the employee is the claimant, the claim is reimbursed through the employee's plan first. When the spouse is the claimant, the claim is reimbursed through the spouse's plan first. When a dependent child is the claimant, the plan of the parent whose birthday falls earlier in the year is the first payer.

If 100% of the covered expenses are not reimbursed by the first payer, the claimant submits the claim to the second payer (the family's other plan) for reimbursement. The claim submitted to the second payer must include copies of the receipts already submitted and the Explanation of Benefits provided by the first payer.

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