allstream May 16, 2005

Dear Pensioner:

We are pleased to advise that effective June 1, 2005 your group benefit plan will be administered by the Great-West Life Assurance Company (GWL), replacing Sun Life Financial.

The Pensioner Benefit Program currently in place remains unchanged. Pensioners will continue to make changes and direct questions to the Allstream Benefit Hotline as in the past. Commencing June 1, 2005, the Great-West Life Assurance Company will provide the health, dental and voluntary semi-private hospital insurance outlined in your current plans. Any life insurance coverage currently in force will continue.

All coverages in your current benefit booklet remain unchanged, however a new booklet referencing GWL and providing information about the new Out of Country insurance carrier will be mailed to you by June 15, 2005.

GWL Health and Dental Claim Form(s)

In transitionlng to GWL your new policy number for your health and dental plans will be:

Health 55410
Dental 55411

Claim Forms with your new policy number pre-populated on the forms are enclosed. Claim Forms are also available by calling the Allstream Benefit Hotline or online from the GWLwebsite. These forms must be used for any claims incurred after May 31, 2005.

Emergency Travel Assistance

GWL's travel assistance plan (Global Medical Assistance - "GMA") card and brochure are enclosed. You should carry this card and brochure with you when travelling any time after May 31, 2005.

GWL Website:

Enclosed find a GWL website brochure. You will be able to register online with the GWL GroupNet plan member website http://www gwl.ca/ Access to this website will enable you to review your claims history, print off claim forms and view a summary of your benefit plan.

New Pay Direct Drug Card

You will be receiving a new Pay Direct Drug Card in the mail the first week of June, 2005. Once you receive your new card(s), please destroy your old card(s)' Should you incur any prescription drug claims after May 31, 2005 and before you receive your drug card, you must completea Health Claim Form. If you should need an additional card (e.g. for a dependent child or student) or misplace your own card, you can download and print a replacement (paper) Pay-Direct drug card from the GWLGroupNet website. Paper cards are accepted at all participating pharmacies. You may also obtain a replacement card by calling the Allstream Benefit Hotline.

Important Information

Health and Dental claims incurred prior to June 1, 2005 must be submitted to Sun Life on Sun Life forms by July 31, 2005.

[] Deductibles paid prior to June 1, 2005 have been transferred to GWL.

Contacts

Allstream Benefit Hotline	1-800-276-7630
Great-West Life Claims	1 800 263 5742 (after May 31, 2005)
Sun Life Claims	1-800-361-6212{prior to June 1, 2005)
David Clement	Sr. Mgr HR Benefits Administration (416) 345-2691
May Sia	Sr. Pension & Benefits Specialist (416) 345-2185
Louise Doucet	Pension & Benefit Specialist (514) 395-2520

We look forward to working with the Great West Life Assurance Company as the new insurance carrier for Allstream benefit programs.

Denis Sutton

Sr, Vice President Human Resources

THE Great-West Life ASSURANCE COMPANY

STANDARD DENTAL CLAIM FORM

Please print

Canadian Dental Association

Canadian Life and Health Insurance Association

PART 1 DENTIST

UNIQUE NO. | SPEC. | PATIENT'S OFFICE ACCOUNT NO.

I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS CLAIM TO THE NAMED DENTIST AND AUTHORIZE PAYMENT DIRECTLY TO HIM/HER.

SIGNATURE OF SUBSCRIBER

PATIENT

LAST NAME GIVEN NAME

ADDRESS APT.

CITY PROV. POSTAL CODE

DENTIST

PHONE NO.

FOR DENTIST'S USE ONLY, FOR ADDITIONAL INFORMATION, DIAGNOSIS, PROCEDURES, OR SPECIAL CONSIDERATION.

DUPLICATE FORM ☐

I UNDERSTAND THAT THE FEES LISTED IN THIS CLAIM MAY NOT BE COVERED BY OR MAY EXCEED MY PLAN BENEFITS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO MY DENTIST FOR THE ENTIRE TREATMENT. I ACKNOWLEDGE THAT THE TOTAL FEE OF $ IS ACCURATE AND HAS BEEN CHARGED TO ME FOR SERVICES RENDERED.
I AUTHORIZE RELEASE OF THE INFORMATION CONTAINED IN THIS CLAIM FORM TO MY INSURING COMPANY/PLAN ADMINISTRATOR. I ALSO AUTHORIZE THE COMMUNICATION OF INFORMATION RELATED TO THE COVERAGE OF SERVICES DESCRIBED IN THIS FORM TO THE NAMED DENTIST.

SIGNATURE OF PATIENT (PARENT/GUARDIAN)

OFFICE VERIFICATION

DATE OF SERVICE DAY	MO.	YR.	PROCEDURE CODE	INTL.TOOTH CODE	TOOTH SURFACES	DENTIST'S FEE	LABORATORY CHARGE	TOTAL CHARGES

THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND THE TOTAL FEE DUE AND PAYABLE, E. & O.E.

TOTAL FEE SUBMITTED

INSTRUCTIONS

All claims under this group benefits plan are submitted through the plan member. We may exchange personal information about claims with the plan member and a person acting on his or her behalf when necessary to confirm eligibility and to mutually manage the claims.

1. Have your dentist complete Part 1.
2. Member completes Parts 2 and 3.
3. If you wish benefits to be paid directly to the dentist, sign the assignment portion of Part 1 above. Assignment of benefits is irrevocable. Great-West Life may discuss details of this claim with the assignee.
4. Send this claim to:

London Benefit Payments
255 Dufferin Avenue
London ON N6A 4K1
1-800-263-5742
(519) 435-6903
TTY line - available for the deaf or hard of hearing
Toll Free: 1-800-990-6654 Phone: (204) 946-7281

PART 2 MEMBER INFORMATION

Plan No. **55411** Division No. _____ Member Identification No. _____

Plan Name **ALLSTREAM CORP. PENSIONER/PRIOR PLAN**

Member Name _____ Date of birth ____/____/____ Day / Month / Year

Member address _____

At Great-West Life, we recognize and respect the importance of privacy. Personal information that we collect will be used for the purposes of assessing your claim and administering the group benefits plan.I authorize Great-West Life, any healthcare provider, my plan administrator, other insurance or reinsurance companies, administrators of government benefits or other benefits programs, other organizations, or service providers working with Great-West Life to exchange personal information when necessary for these purposes. I authorize the use of my Social Insurance Number for tax reporting purposes and as an identification number where it is required in the administration of the plan. I certify that the information given is true, correct and complete to the best of my knowledge.

Member's Signature _____ Date _____

PART 3 COORDINATION OF BENEFITS

1. Patient's relationship to you _____ 2. Patient's Date of Birth: ____/____/____ Day / Month / Year
3. a) Are you or any other member of your family entitled to benefits under any other plan? ☐ Yes ☐ No

   If yes, name of family member insured _____ Relationship to employee _____

   Name of other insurance company _____ Policy number _____

   b) Is any member of your family (other than yourself) insured as an employee under this plan? ☐ Yes ☐ No

   c) If yes to questions 3 a) or b), and the patient is a dependent child, please provide spouse's Date of Birth ____/____ Day / Month
4. Is this treatment required as the result of an accident? ☐ Yes ☐ No If yes, give date, location, and explain how accident happened

   _____
5. Is a claim being made for Worker's Compensation Benefits? ☐ Yes ☐ No
6. If claim is for denture, crown or bridge, is this initial placement? ☐ Yes ☐ No If no, give date of prior placement and reason for replacement

   _____

M445D(55411) BIL-5/05

THE Great-West Life ASSURANCE COMPANY

HEALTHCARE EXPENSES STATEMENT

INSTRUCTIONS: Attach the bills and receipts for all expenses and itemize them by providing all the information requested. Note: Drug bills and receipts, other than those required for government drug plans, are part of our records and will not be returned. Therefore, please retain the itemization of expenses that will accompany our cheque or explanation for Income Tax purposes.

IMPORTANT: Please answer all questions. This claim will be returned to you if it is incomplete or contains errors. All claims under this group benefits plan are submitted through the plan member. We may exchange personal information about claims with the plan member and a person acting on his or her behalf when necessary to confirm eligibility and to mutually manage the claims.

Please print

MEMBER INFORMATION

PLAN NUMBER	DIVISION NO.	PLAN NAME
55410		ALLSTREAM CORP. PENSIONER/PRIOR PLAN

MEMBER IDENTIFICATION NUMBER ☐☐☐☐☐☐☐☐☐

MEMBER NAME

DATE OF BIRTH Year Month Day

ADDRESS: NUMBER AND STREET TOWN PROVINCE POSTAL CODE

PHONE # HOME: WORK:

COORDINATION OF BENEFITS

Are you or any other member of your family entitled to benefits under any other plan?

☐ Yes ☐ No

If "Yes", name of family member insured _____

Relationship to member _____

Name of other insurance company _____

Policy Number _____

Is any member of your family (other than yourself) insured as a member under this plan?

☐ Yes ☐ No

If "Yes" to either question above, and the patient is a dependent child, please provide spouse's date of birth _____ / _____ Day Month

Is treatment required as the result of an accident? ☐ Yes ☐ No If "Yes", give date, location and explain how accident happened _____

Is a claim being made for Worker's Compensation Benefits? ☐ Yes ☐ No

SEND THIS CLAIM TO:

London Benefit Payments
255 Dufferin Avenue
London ON N6A 4K1
1-800-263-5742
(519) 435-6903
TTY line - available for the deaf or hard of hearing
Toll Free: 1-800-990-6654 Phone: (204) 946-7281

DEPENDENT INFORMATION

Patient Name	Relationship to Member	Date of Birth Year	Mth	Day

CLAIM DETAILS

	DRUG EXPENSES		OTHER EXPENSES		
Patient Name	Number of Receipts	Total Charge	Type of Expense	Nature of Illness	Total Charge

(IF ADDITIONAL SPACE IS NEEDED, ATTACH SEPARATE PAGE)

At Great-West Life, we recognize and respect the importance of privacy. Personal information that we collect will be used for the purposes of assessing your claim and administering the group benefits plan. I authorize Great-West Life, any healthcare provider, my plan administrator, other insurance or reinsurance companies, administrators of government benefits or other benefits programs, other organizations, or service providers working with Great-West Life to exchange personal information when necessary for these purposes. I authorize the use of my Social Insurance Number for tax reporting purposes and as an identification number where it is required in the administration of the plan. I certify that the information given is true, correct and complete to the best of my knowledge.

MEMBER'S SIGNATURE _____ DATE _____

M635D(55410) BIL-5/05