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Investments. Insurance. Advice.

GROUP BENEFITS
PLAN MEMBER ENROLMENT FORM

INSTRUCTIONS

Section 1 is to be completed by the plan administrator. All remaining sections are to be completed by the plan member.

To avoid delays, please complete the required information, sign and date the form.

The Plan Administrator must confirm eligibility prior to completing this form.

If enrolment is not made on time, coverage may be limited or denied based on proof of insurability. Late Applicants must complete and attach the Health Evidence Questionnaire (GL1364).

Retain a copy for your records.

1. EMPLOYMENT INFORMATION

Group _____ Account _____ Class _____ Certificate _____

Group Name _____

Employment Commenced _____ (MMM/DD/YYYY) ☐ Full-time ☐ Part-time ☐ Contract

Salary $ _____ Hrs per week _____ ☐ Hourly ☐ Weekly ☐ Bi-weekly ☐ Semi-monthly ☐ Monthly ☐ Annually

Occupation _____ Province of Residence _____ Province of Employment _____

☐ Health Care Spending Account (if applicable) Deposit Amount $ _____

☐ Personal Spending Account (if applicable) Deposit Amount $ _____

I confirm this plan member is actively working the minimum number of hours indicated in the Policy and is presently living in Canada. I certify that all the information provided herein is complete and accurate.

Signature _____ (Plan Administrator) Date _____ (MMM/DD/YYYY)

Plan Administrator Email _____ Phone Number (_____) _____

2. PLAN MEMBER INFORMATION

Plan Member _____ (First Name) _____ (Middle) _____ (Last Name)

Address _____ (Street) _____ (City) _____ (Province) _____ (Postal Code)

Date of Birth _____ (MMM/DD/YYYY) Sex ☐ M ☐ F ☐ X Provincial Health Plan coverage? ☐ Yes ☐ No

Marital Status ☐ Single ☐ Married/Civil Union ☐ *Common-Law/Partnered Co-habitating since: _____ (MMM/DD/YYYY)

* Common-Law Spouse means that I have lived with this person as my spouse or partner for a continuous period of at least 12 months, and I have publicly represented this person to be my common-law spouse.

Email _____

By providing your email address, you consent to the collection and use of your email address by Co-operators Life Insurance Company for the purpose of managing your access to the Benefits Now® portal for Plan Members. If you no longer consent to Co-operators Life Insurance Company collecting and using your email address for this purpose, please send notification to Group_Client_Services@cooperators.ca.

3. REFUSAL OF BENEFITS

Coverage for Extended Health Care and Dental can be refused if you and/or your spouse/dependents have similar coverage through your spouse's employer. I understand the group benefits offered to me, but **I decline** to participate in:

Extended Health Care for ☐ Myself and my spouse/dependents ☐ My spouse/dependents only

Dental for ☐ Myself and my spouse/dependents ☐ My spouse/dependents only

Spouse's Insurer _____

To add these benefits at a later date, you must apply for coverage within 31 days of loss of spousal coverage. After 31 days, proof of insurability may be required and coverage may be restricted or denied.

All changes must be initialled by the Plan Member.

4. DEPENDENT INFORMATION

This information is required if your plan includes Extended Health Care, Dental and/or Dependent Life coverage.

If there are more than four dependents, please attach a separate list.

You must notify Co-operators Life Insurance Company if there are any changes in student status.

Spouse _____ (First Name) _____ (Middle) _____ (Last Name)

Date of Birth _____ (MMM/DD/YYYY) Sex ☐ M ☐ F ☐ X Provincial Health Plan coverage? ☐ Yes ☐ No

ELIGIBLE DEPENDENT(S)

1. _____ (First Name) _____ (Middle) _____ (Last Name) Date of Birth _____ (MMM/DD/YYYY)
   ☐ Post-secondary Student ☐ Disabled Dependent** Sex ☐ M ☐ F ☐ X Provincial Health Plan coverage? ☐ Yes ☐ No
2. _____ (First Name) _____ (Middle) _____ (Last Name) Date of Birth _____ (MMM/DD/YYYY)
   ☐ Post-secondary Student ☐ Disabled Dependent** Sex ☐ M ☐ F ☐ X Provincial Health Plan coverage? ☐ Yes ☐ No
3. _____ (First Name) _____ (Middle) _____ (Last Name) Date of Birth _____ (MMM/DD/YYYY)
   ☐ Post-secondary Student ☐ Disabled Dependent** Sex ☐ M ☐ F ☐ X Provincial Health Plan coverage? ☐ Yes ☐ No
4. _____ (First Name) _____ (Middle) _____ (Last Name) Date of Birth _____ (MMM/DD/YYYY)
   ☐ Post-secondary Student ☐ Disabled Dependent** Sex ☐ M ☐ F ☐ X Provincial Health Plan coverage? ☐ Yes ☐ No

**You are required to complete a Dependent Health Evidence Questionnaire once the disabled dependent reaches the dependent age maximum as listed in the policy.

CO-ORDINATION OF BENEFITS

Complete this section if your plan includes Extended Health Care and/or Dental and you have not refused such coverage for your spouse/dependents in section 3.

Please check if you and your spouse are eligible for the following benefits from another source or company.

☐ Extended Health Care and Dental Coverage ☐ Extended Health Care Coverage ONLY ☐ Dental Coverage ONLY

If Co-ordination of Benefits is terminated or changed, notification is required within 31 days.

5. BENEFICIARY INFORMATION

Percentage allocation will be deemed equal unless indicated otherwise. Percentages must total 100%. If you do not name a beneficiary, your "estate" will be the beneficiary. A contingent beneficiary is applicable if the primary beneficiary predeceases the Plan Member. If no trustee is named for minor children, the funds are paid to the Public Trustee (or equivalent government official) until the children reach the age of majority. In Quebec, the Civil code provisions apply. It is not necessary to designate a trustee. The benefits will be paid directly to the child's tutor, without the requirement for a designation of a trustee.

PRIMARY BENEFICIARY(IES)

First Name	Middle	Last Name	Relationship	% Allocated
				%
				%
				%

CONTINGENT BENEFICIARY

A contingent beneficiary is applicable if the primary beneficiary predeceases the Plan Member.

First Name	Middle	Last Name	Relationship	% Allocated
				%

In provinces other than Quebec, if a designated beneficiary is a minor, please name a trustee. Insurance proceed will be paid to the trustee if the beneficiary has not reached the age of majority at the time the insurance proceeds are payable.

Trustee _____ (First Name) _____ (Middle) _____ (Last Name) _____ (Relationship)

In Quebec, the designation of your spouse as a beneficiary is irrevocable unless you declare otherwise. I designate my spouse as a revocable beneficiary: ☐ Yes

6. PRIVACY

Co-operators Life Insurance Company Privacy Statement

At Co-operators, we recognize and respect the importance of privacy. When you apply for insurance or open an account with us, we will ask for your consent to collect, use, keep and share your personal information. We will explain what information we need, what we will use it for and who we will share it with. We will open a confidential file to collect, use, keep and share your personal information for the purposes of confirming your identity, reviewing your insurance needs and determining suitability of our products and services for you, assessing your application for insurance, issuing and administering your policy, including assessing and processing claims, administering your investments, meeting our contractual and regulatory obligations, detecting and preventing fraud, and performing business and statistical analysis. We will not share your personal information for other purposes, except with your consent or as required or permitted by law.

We may tell you about products and services that may be of interest to you. You can tell us what information you want to receive from us and you can withdraw your consent at any time. You may access and correct, if needed, the personal information in your file by sending us a request in writing.

We limit access to your personal information to our staff and other people we have authorized who need to use it to perform their duties. This may include our third-party service providers who may use your personal information for processing, storage, analysis and disaster recovery purposes outside of Canada. They could be required by law to give your personal information to courts, governments or regulators outside of Canada. To protect your personal information, we ensure that privacy and security requirements are included in all third-party service provider contracts.

You can find more details about the Co-operators privacy policy at www.cooperators.ca. If you have any questions regarding our privacy policies or about how we collect, use, keep and share your personal information, please contact our Privacy Officer at The Co operators at 1-888-887-7773, or by e-mail: privacy@cooperators.ca

7. PLAN MEMBER SIGNATURE

I have read and understood the section entitled “Privacy” and I consent to the collection, use and disclosure of my personal information for the purposes stated. I hereby apply for group benefits coverage and authorize the deduction from my pay and remittance to Co-operators any contributions required under the group benefits plan. I hereby authorize the employer, group plan administrator, Co-operators or their agents, or any other person or organization having any relevant information regarding me, my spouse or dependents to release and exchange all information necessary for the purposes of determination of eligibility for benefits and administration of the group benefits plan. I confirm I am authorized to act on behalf of my spouse and/or dependents for such purposes. I declare that the information provided is true, complete and accurate. Any copy of this authorization shall be as valid as the original.

Signature _____ Date _____
MMM/DD/YYYY