the co-operators®
A Better Place For You®

GROUP BENEFITS
LIFE WAIVER OF PREMIUM
PLAN MEMBER STATEMENT

MAILING ADDRESS

Mail: Co-operators Life Insurance Company
Group Life Claims Department
1900 Albert Street
Regina SK S4P 4K8

Fax: 1-866-889-9925

INSTRUCTIONS

Please print clearly and be sure all sections are complete to avoid delays in processing the claim.

1. PLAN MEMBER INFORMATION

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

Group _____ Account _____ Certificate _____

Plan Sponsor/Employer _____ Phone Number (_____) _____

Date of Birth* _____ (MMM/DD/YYYY) ☐ Male ☐ Female Height _____ Weight _____

* If age 60 or over, enclose a copy of your birth certificate

Social Insurance Number** _____

** Social Insurance Number is for taxable plans and any Contribution To Pension benefits.

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

Phone Number (_____)_____ Cell Number (_____)_____

If you would like The Co-operators to communicate with you by email about this claim, please provide your email _____

Co-operators Life Insurance Company uses reasonable safeguards to protect all information it collects, uses, retains and discloses in the course of conducting business. However, the internet is not a secure medium and we do not use email encryption. As such, we cannot guarantee complete privacy and confidentiality of any email transmissions. This includes the email text and any attachments. By authorizing communication by email, you are acknowledging that you have read and understood this notice and disclaimer and are consenting to the transmission of your personal information using email knowing the email and any attachments may be subject to unauthorized access, use or disclosure by third parties. You agree that Co-operators Life Insurance Company is not responsible or liable for any damages or losses you or any other person may suffer as a result of any breach of privacy, confidentiality or security by transmission of your personal information using email communication. If you no longer wish to communicate with Co-operators Life Insurance Company by email, please send notification to Group_life_claims@cooperators.ca.

2. CLAIM INFORMATION

Describe your present medical condition, its cause and history _____

_____

_____

_____

Date Symptoms Began _____ (MMM/DD/YYYY) Date of first treatment for this illness/injury _____ (MMM/DD/YYYY)

Medical condition has prevented me from working since _____ (MMM/DD/YYYY)

Have you ever had a similar injury or illness in the past? ☐ Yes ☐ No

If yes, please describe your condition, the date of its onset, any treatment you received for it, and any time lost from work because of it.

_____

_____

_____

List all physicians you have seen for your present medical condition (ensure copies of all available specialists' reports are provided):

Physician	Address	Dates Seen From	Dates Seen To	Next Appointment Date
		MMM/DD/YYYY	MMM/DD/YYYY	MMM/DD/YYYY
		MMM/DD/YYYY	MMM/DD/YYYY	MMM/DD/YYYY
		MMM/DD/YYYY	MMM/DD/YYYY	MMM/DD/YYYY

List any dates of hospitalization From _____ (MMM/DD/YYYY) To _____ (MMM/DD/YYYY)

Plan Member _____ _____ _____
First Name Initial Last Name

2. CLAIM INFORMATION (CONTINUED)

Has your physician told you to restrict your activities in any way? ☐ Yes ☐ No

If yes, describe what he/she told you about restricting your activities _____

_____

How do these restrictions interfere with your ability to perform your job duties? _____

_____

Have you discussed a return to work with your employer? ☐ Yes ☐ No

☐ Own Occupation Date _____ MMM/DD/YYYY
☐ Modified Occupation Date _____ MMM/DD/YYYY
☐ Part-Time Date _____ MMM/DD/YYYY
☐ Full-Time Date _____ MMM/DD/YYYY

Have you discussed a return to work with your physician? ☐ Yes ☐ No

☐ Own Occupation Date _____ MMM/DD/YYYY
☐ Modified Occupation Date _____ MMM/DD/YYYY
☐ Part-Time Date _____ MMM/DD/YYYY
☐ Full-Time Date _____ MMM/DD/YYYY

3. OCCUPATION AND EDUCATION INFORMATION

EDUCATION TRAINING

Indicate the highest grade level of education completed ☐ Grade 6 or under ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ 13

Type of degree, diploma, or certificate _____

Other training, special or vocational courses _____

_____

_____

WORK EXPERIENCE

Present Employment

Occupation _____ Date Started _____ MMM/DD/YYYY

Duties _____

Previous Employment

Please complete the following, providing details of your previous positions

1. Employer _____ Job Title _____ Dates of Employment _____
Duties _____

2. Employer _____ Job Title _____ Dates of Employment _____
Duties _____

3. Employer _____ Job Title _____ Dates of Employment _____
Duties _____

Job Skills

What skills have you acquired in your current and previous jobs? (e.g. typing, operation of equipment, supervisory skills, etc) Where appropriate, give level of proficiency.

_____

_____

Community Interests

Outline your past or present involvement with any community or volunteer organizations.

_____

Hobbies

_____

Plan Member _____ _____ _____
First Name Initial Last Name

4. PRIVACY

Co-operators Life Insurance Company Privacy Statement

At The 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

5. PLAN MEMBER AUTHORIZATION

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 authorize any physician, hospital, clinic, pharmacy or any other medical or health care provider or facility, the group plan administrator or their agent, any insurance company, reinsurer, provincial health insurance plan, government department or agency, my employer or former employers, and any other person, organization or institution having any medical, employment, vocational , financial or other relevant personal information or records regarding me to release to and exchange with Co-operators Life Insurance Company, the group plan administrator or their representatives and/or agents, any and all such information necessary for the purposes of investigating and confirming the accuracy and validity of my claim, determine my eligibility for benefits, administer my claim, assess and facilitate my ability to return to work and administer the group benefits plan and coverage.

In consideration for any payment of benefits made to me by Co-operators Life Insurance Company, the policyholder, or plan administrator (the “payor”), I hereby agree to refund, in accordance with the provisions of the policy/plan document, from any source as defined under All Source Benefit and/or Other Income, any monies that may be due to the payor and further irrevocably assign all right, title, and interest of such monies and any group insurance proceeds to the payor for such purpose.

I hereby authorize Co-operators Life Insurance Company to deposit disability payments directly to my account and to exchange my relevant financial information with my financial institution for such purpose. This authorization shall remain valid for the duration of my claim unless revoked by me in writing.

I understand that my refusal or withdrawal of consent may delay claims adjudication or result in the denial of my claim. I declare that the information provided in this Plan Member Statement and any statements provided in any personal or telephone interview relating to this claim are/will be true, complete and accurate. This authorization shall remain valid for the duration of the claim unless revoked in writing by me. Any copy of this authorization shall be as valid as the original.

For Quebec residents - Under this assignment, the definition of All Source Benefits and/or Other Income does not include the benefits paid by the Commission de la santé et sécurité du travail or by the Commission des lésions professionnelles.

Plan Member Signature _____ Date _____
MMM/DD/YYYY