the co-operators
A Better Place For You®

GROUP BENEFITS DISMEMBERMENT STATEMENT

MAILING ADDRESS	PLAN SPONSOR INSTRUCTIONS
Mail: Co-operators Life Insurance Company Group Life Claims 1900 Albert Street Regina, SK S4P 4K8 Fax: 1-866-889-9925	For clients not billed by The Co-operators, please attach a copy of the plan member's enrolment form and a copy of the billing. If the sum insured is based on salary, please attach a copy of the plan member's pay stub for the last full pay period.

1. PLAN SPONSOR

Plan Member ______________________ ____ ______________________
First Name Initial Last Name

Group ______________ Account ______________ Certificate ______________

Date of Birth ______________
MMM/DD/YYYY

Date plan member became insured under The Co-operators AD&D policy ______________ **and** with a previous carrier's policy ______________
MMM/DD/YYYY MMM/DD/YYYY

Date of Employment ______________ Date Last Worked ______________ Date Returned to Work ______________
MMM/DD/YYYY MMM/DD/YYYY MMM/DD/YYYY

Is condition due to injury or illness arising out of employment? ☐ Yes ☐ No

If "Yes", has the plan member applied for Workers' Compensation benefits? ☐ Yes ☐ No

Provide any additional information which might assist us in considering this claim ______________

Name of Plan Sponsor ______________

Phone Number (_____)______________ Cell Number (_____)______________ Fax Number (_____) ______________

Address ______________ ______________ ______________ ______________
Street City Province Postal Code

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.

Form completed by ______________ Title ______________
Name (please print)

I hereby declare that the answers to the above questions are accurate and complete.

Authorized Signature ______________ Date ______________
MMM/DD/YYYY

2. PLAN MEMBER

Loss for which you are claiming ______________

Is loss due to:

☐ **Disease** Date of Diagnosis ______________
MMM/DD/YYYY

OR

☐ **Accident** Date of Accident ______________ Time ________ ☐ a.m. ☐ p.m. Location of Accident ______________ ______
MMM/DD/YYYY City Province

Describe the circumstances surrounding the accident ______________

____

Was alcohol involved in the events surrounding your accident? ☐ Yes ☐ No

Did the accident involve another party? ☐ Yes ☐ No If yes, provide the name of the other party/parties involved in the accident

Name ______________ Address ______________

Name ______________ Address ______________

Was it reported to the police? ☐ Yes ☐ No If yes, attach a copy of the police report.

Were any charges laid? ☐ Yes ☐ No If yes, against whom? ______________

What were the charges? ______________

Plan Member ____________________ ____ ____________________
First Name Initial Last Name

2. PLAN MEMBER (Continued)

List dates of hospitalizations from __________ (MMM/DD/YYYY) to __________ (MMM/DD/YYYY). Name of Institution ____________________

Provide names and addresses of attending physician(s)

Physician	Address	Date Seen
		MMM/DD/YYYY
		MMM/DD/YYYY
		MMM/DD/YYYY

3. AUTHORIZATION

I hereby authorize any physician, hospital, clinic, pharmacy or any other medical or health care provider or facility, the group plan administrator and/or adjudicator 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 or other relevant personal information or records regarding me to release to and exchange with Co-operators, 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, to determine my eligibility for benefits or to administer my claim. I authorize the use of my Social Insurance Number for the purposes of tax reporting and for the identification and administration of any benefits. 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 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.

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Plan Member Signature ____________________ Date __________
MMM/DD/YYYY

Address ____________________ __________ __________ __________
Street City Province Postal Code

Telephone (____) __________

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