

# GROUP BENEFITS CRITICAL DISEASE STATEMENT

FOR OFFICE USE ONLY

## MAILING ADDRESS

Mail: Co-operators Life Insurance Company  
Group Life Claims  
1920 College Avenue  
Regina SK S4P 1C4  
  
Fax: 1-866-889-9925

## PLAN SPONSOR INSTRUCTIONS

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 \_\_\_\_\_ Possible Return to Work Date \_\_\_\_\_  
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

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

Critical Disease/Diagnosis \_\_\_\_\_

Date of onset of symptoms \_\_\_\_\_ Date of Diagnosis \_\_\_\_\_  
MMM/DD/YYYY MMM/DD/YYYY

List dates of hospitalizations from \_\_\_\_\_ to \_\_\_\_\_ Name of Institution \_\_\_\_\_  
MMM/DD/YYYY MMM/DD/YYYY

Provide names and addresses of attending physician(s)

Physician	Address	Date Seen
		_____ <small>MMM/DD/YYYY</small>
		_____ <small>MMM/DD/YYYY</small>
		_____ <small>MMM/DD/YYYY</small>

## 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 \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Plan Member \_\_\_\_\_  
First Name Initial Last Name

### 3. PLAN MEMBER AUTHORIZATION

#### Co-operators Life Insurance Company Privacy Statement

Co-operators Life Insurance Company is committed to protecting the privacy, confidentiality, accuracy and security of the personal information that it collects, uses, retains and discloses in the course of conducting business.

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 The 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 (\_\_\_\_\_) \_\_\_\_\_