

GROUP BENEFITS CRITICAL ILLNESS CLAIMANT STATEMENT

This guide is designed to assist you in the claim submission process.

CRITICAL ILLNESS BENEFITS

Critical Illness Benefits can be used to offset uninsured medical expenses, provide home renovations for wheelchair accessibility, provide nursing care, help with ongoing responsibilities/payments such as childcare, mortgage loan payments, etc.

Any Critical Illness Benefit deemed payable is payable to the Plan Member.

You are not entitled to Critical Illness Benefits automatically. To qualify for benefits, we must determine that:

- Your Group contract provides coverage for the specified illness/condition claimed;
- You have submitted satisfactory proof of the covered condition as defined in your Group contract;
- You have completed a survival period (as defined in the covered condition); and
- You have met the terms and conditions in your Group contract.

Please refer to your Group Contract to confirm coverage for the condition claimed.

THE FOLLOWING INFORMATION IS REQUIRED

Plan Sponsor Statement

Ensure the Plan Sponsor Statement is submitted to our office by your employer.

Claimant Statement

Asks general information about you, your condition and the nature of your symptoms and treatment for the purpose of assessing your claim. Please complete all questions on this form and be sure to include your Group and Account Number.

Physician Statement

Ask the specified physician to complete the form. Ensure that the physician includes copies of office records, investigations, consultation reports and any additional medical information that may assist us with your claim.

You are responsible for providing medical proof that you are entitled to receive Critical Illness Benefits. Your physician may request a fee for completing claim forms which will be your responsibility. If we request information directly from your physician, we may offer to pay your physician a correspondence fee.

CLAIM INTERVIEW

An insurance company representative may telephone you to obtain information about your medical history and current condition.

AUTHORIZATION AND PRIVACY

We need your permission to obtain information that will help us assess your claim. By signing the authorization request, you give us permission to obtain this information from your treatment providers, other insurers and hospitals where you received treatment.

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

Co-operators Life Insurance Company will abide by all federal and provincial privacy legislation which governs the protection of all personal information in its custody. For further information regarding Co-operators Life Insurance Company privacy policies, please refer to our website at www.cooperators.ca.

CONTACT INFORMATION

If you have any questions or if you need help with your Critical Illness claim, please contact us at 1-866-442-3098. Please have your Group and Account number available.

GROUP BENEFITS CRITICAL ILLNESS CLAIMANT STATEMENT

MAILING ADDRESS

Mail: Co-operators Life Insurance Company
Life Claims Department
1920 College Avenue
Regina SK S4P 1C4

Phone: 1-866-442-3098
Fax: 1-866-889-9925

INSTRUCTIONS

Please print clearly and be sure all sections are complete to avoid delays in processing the claim.
The completed form can be faxed to the number provided or the original can be mailed to the address provided.
Condition claimed may or may not be covered under your Policy. **Please refer to your Group Contract to confirm coverage for the condition claimed.**

1. PLAN MEMBER INFORMATION

Group _____ Account _____ Certificate _____

Name _____
First Name Initial Last Name

Address _____
Street City Province Postal Code

Phone (_____) _____ Email _____

Date of Birth _____
MMM/DD/YYYY

2. MEDICAL INFORMATION

1. Indicate the diagnosis provided:

2. Date of Diagnosis _____
MMM/DD/YYYY

3. Date Plan Member was Advised of Diagnosis _____
MMM/DD/YYYY

4. Name and address of the physician who provided the diagnosis:

5. Was this physician the Plan Member's regular family doctor? Yes No

If no, who made the referral to this physician? _____

Please provide the full name and address of the referral physician as well as the regular family physician:

6. Please list the symptoms that led to the first consultation for this illness. Please state the onset date and severity of each symptom:

Symptom	Onset Date	Severity

7. Date a Physician was first consulted regarding this illness _____
MMM/DD/YYYY

8. Name and address of physician first consulted:

2. MEDICAL INFORMATION (CONTINUED)

9. Date Treatment Began _____
MMM/DD/YYYY

10. Please provide details of the current treatment, including dates and details of any hospital investigations or in-patient treatment:

11. Has there been a referral to any treatment facility, specialized medical facility or care provider for on-going care? Yes No

If yes, please indicate where:

12. Has the Plan Member previously suffered from a similar or related illness? Yes No

If yes, please provide details and dates:

13. Have any blood relatives suffered from a similar or related illness? Yes No

If yes, state the relationship of relative, nature of illness and the age at which the illness was diagnosed:

14. Does the Plan Member currently use or have they ever used any form of tobacco, marijuana, nicotine products or nicotine substitute (nicotine products including cigarettes, cigarillos, cigars, pipes, chewing tobacco, snuff, nicotine gum or patch or any other nicotine products)? Yes No

If yes, which substance(s) are or were used? _____

What quantity or number are or were used per day? _____ Date last used _____
MMM/DD/YYYY

15. Please provide names and addresses for all treating physicians or hospitals at which treatment was received for this illness (include dates and reasons attended):

3. 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 apply for group benefits coverage and authorize the deduction from my pay and remittance to The Co-operators any contributions required under the group benefits plan. I hereby authorize the employer, group plan administrator, The 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.

Signed at _____ this _____ day of _____ 20 _____
City, Province Date Month Year

Name of Plan Member

Signature of Plan Member

4. PRIVACY STATEMENT

CO-OPERATORS LIFE INSURANCE COMPANY PRIVACY STATEMENT

The Co-operators 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.

At The Co-operators, we recognize and respect the importance of privacy. When you enrol for insurance coverage or submit a claim, we establish a confidential file and collect, use and disclose your personal information for the purposes of issuing, administering, adjudicating and/or servicing your insurance. 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 persons we have authorized who have a need to know it to perform their duties. Our systems and procedures are designed to prevent the loss, misuse, unauthorized access, disclosure, alteration, or destruction of your information. Our commitment to security extends to the contracts and agreements we sign with external suppliers and service providers. We may store or process your personal information in Canada, the United States or other countries for processing, storage, analysis or disaster recovery and, under applicable law, governments, courts, law enforcement or regulatory agencies, may, by lawful order, obtain disclosure of your personal information. 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 the collection, use and disclosure of your personal information, please contact our Privacy Officer at The Co-operators at Priory Square, Guelph, ON, N1H 6P8, Tel: 1-888-887-7773, E-mail: privacy@cooperators.ca (please include The Co-operators company you deal with in your inquiry).

If you do not agree with our use and disclosure of your information in connection with your application and servicing any policy that we issue, we will not be able to offer you the insurance product you are interested in, service your insurance or adjudicate your claim.