the co-operators®
A Better Place For You®

OPTIONAL ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE APPLICATION

Accidents happen everywhere -- on the job, at home, on holidays and in many situations.
This insurance provides an opportunity to purchase economical supplemental
accidental death and dismemberment insurance.

GL1726 (10/14)

the co-operators®
A Better Place For You®

OPTIONAL ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE APPLICATION

GENERAL INFORMATION

HOW DOES IT WORK?

Coverage is available in units as outlined in the rate sheet supplied to your employer. You can choose the amount of protection that is right for you.

As an example, an individual wishes to purchase 5 units (5 x $10,000 = $50,000) of optional accidental death and dismemberment coverage.

If you choose:

Family Plan:	Your spouse will be insured for: 40% of your coverage (if you have children) 50% of your coverage (if you don't have children)	Your dependent children will be insured for: 10% of your coverage (if you have a spouse) 15% of your coverage (if you do not have a spouse)
Employee Plan:	If the cost is $.036/1000 then, $.036 X 50 (amount of coverage being purchased/1000) = $1.80 per month.	
Family Plan:	If the cost is $.045/1000 then, $.045 X 50 (amount of coverage being purchased/1000) = $2.25 per month.	

THE SCHEDULE OF LOSSES IS AS FOLLOWS:

100% of approved benefit:	life both hands or feet sight of both eyes one hand & one foot one hand or foot & sight of one eye use of both hands, both arms or both legs paraplegia hemiplegia quadriplegia
75% of approved benefit:	one arm or leg use of one arm or leg
50% of approved benefit:	one hand or foot sight of one eye speech hearing in both ears use of one hand
25% of approved benefit:	thumb & index finger (of same hand)
16.7% of approved benefit:	hearing in one ear.

HOW DO I APPLY?

To apply, complete the attached application form and forward to:

CO-OPERATORS LIFE INSURANCE COMPANY
ATTENTION: GROUP BENEFITS ADMINISTRATION DEPARTMENT

1920 COLLEGE AVENUE
REGINA, SK
S4P 1C4

www.cooperators.ca/groupbenefits > Forms

Your coverage will take effect once you receive written confirmation from The Co-operators.

Your premium payment is made by payroll deduction.

For more information and application forms contact your plan administrator.

the co-operators®
A Better Place For You®

GROUP BENEFITS OPTIONAL ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE APPLICATION

To avoid delays, please complete the required information by printing clearly in ink.
Underwritten by Co-operators Life Insurance Company

1. PLAN MEMBER INFORMATION

Group _____ Account _____ Certificate _____ Group Name _____

The beneficiary of this insurance is as designated on my enrolment form for Group Life Insurance.

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

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

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

2. PLAN INFORMATION

Plan: ☐ Employee Plan ☐ Family Plan Amount of Insurance: $ _____

3. PLAN MEMBER QUESTIONS

1. In the past two years:

   a) Have you used marijuana, or sedative, tranquillizing, hallucinogenic or narcotic drugs, other than as prescribed by a physician? ☐ Yes ☐ No

   If yes, specify _____

   b) Have you taken, or been advised to take, treatment or counselling for alcohol abuse (including becoming a member of Alcoholics Anonymous)? ☐ Yes ☐ No

2. What is your average alcohol consumption? Frequency of use: ☐ Daily ☐ Weekly ☐ Monthly ☐ Other _____

   Amount consumed on each occasion _____ Date last used _____ (MMM/DD/YYYY)

3. In the past two years, have you been treated for or had any indication of dizziness, fainting, convulsions, nervous breakdown, epilepsy, stroke or disorder of the brain or nervous system, or disorder of the eyes or ears? ☐ Yes ☐ No

   If yes, specify _____

4. DECLARATION & 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.

APPLICANT AUTHORIZATION AND CONSENT

I authorize any person or organization who maintains my personal and health records or information to provide Co-operators (or its agents, representatives, and administrators) with my personal and health information for the purpose of underwriting my application for insurance coverage, evaluating my eligibility for any insurance coverage, and adjudicating my insurance claim(s). I authorize Co-operators to release my personal and health information to my physician, the Public Health authorities, and Co-operator's re-insurer(s), when requested. This authorization will remain valid unless I revoke it in writing. A copy of this authorization will be as effective as the original.

APPLICANT ACKNOWLEDGEMENT AND DECLARATION

I understand that Co-operators (or its agent, representatives, and administrators) may ask me to undergo a medical or paramedical examination(s) to evaluate my eligibility for insurance coverage. If I refuse to undergo such examination(s), this may result in the delay or denial of my application for insurance coverage. I acknowledge that any information I disclose in any paramedical or medical examination or on any medical evidence form(s), questionnaire(s) or other statement(s) given as evidence of insurability will form part of my application for insurance coverage. I certify and declare that I have disclosed true, complete, and accurate information on my application for insurance coverage. I understand and acknowledge that a failure to disclose true, complete and accurate information or a misrepresentation of any material fact(s) may result in Co-operators voiding my insurance coverage.

Signature _____ (Plan Member's Signature) Date _____ (MMM/DD/YYYY)