

**APPLICATION FOR GROUP SHORT TERM DISABILITY BENEFITS**

**Employee Statement** (Please Print)

*Please answer all questions*

**CLAIMANT INFORMATION**

Claimant's name  
 Miss    Mr.    Mrs.    Ms.  
Last name First Name

Policy / plan no.	Account No.	S.I.N. No. (for taxable plans only)
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Date of Birth Day      Month      Year	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Telephone No. (      )
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If age 60 over, copy of birth certificate must be enclosed with claimant's statement

Address

No. & Street      Suite / Apt. No.      City / Town      Province      Postal Code

Briefly describe your duties . . . . .

.....

Please provide education level - 1 2 3 4 5 6 7 8 9 10 11 12 Secondary -

Describe your present medical condition, its cause and history . . . . .

.....

Date of first treatment for this illness/injury Day      Month      Year	Medical condition has prevented you from working since Day      Month      Year	Have you or did you attempt to return to work? <input type="checkbox"/> No <input type="checkbox"/> Yes Date returned: .....
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Have you ever had a similar injury or illness in the past?    No    Yes   If "Yes", describe your condition and the original date of illness or injury.

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List all physicians you have seen for your present medical condition (Attach copies of all available specialists' reports)							
Physician's Name	Address	Dates Seen		Dates of Any Hospitalization		Next Appointment Date	
		From	To	From	To		

**ACCIDENT INFORMATION - COMPLETE ONLY IF CLAIM IS THE RESULT OF AN ACCIDENT.**

Date of Accident Day      Month      Year	Time of accident <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	Was work being done for an employer at time of accident? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Particulars of accident: . . . . .

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If your condition is the result of an injury/accident or motor vehicle accident, please describe the events surrounding the accident:

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a) Was another party at fault?    Yes    No

b) Was alcohol involved in the events surrounding the accident?    Yes    No

c) Was it reported to police?    Yes    No   (if Yes, attach a copy of police report)

d) Were any charges laid?    Yes    No   If Yes, against whom? .....

e) Are you pursuing a claim for wage loss against a third party?    Yes    No   If No, please give reasons:

.....

**Employee Statement (continued)**

Employee Name: \_\_\_\_\_

Are you claiming or receiving any other disability, wage loss, and/or retirement benefits? <input type="checkbox"/> No <input type="checkbox"/> Yes If "Yes", complete this section .				
Type	Amount	Frequency	Effective	Claim No.
<input type="checkbox"/> WCB/WSIB				
<input type="checkbox"/> CPP/QPP				
<input type="checkbox"/> Auto Insurance				
<input type="checkbox"/> EI				
<input type="checkbox"/> Other (e.g. legal action) .....				

**NOTE: ATTACH COPIES OF ALL CORRESPONDENCE YOU HAVE RECEIVED, RELATED TO THE ABOVE MATTER**

**CO-OPERATORS LIFE INSURANCE COMPANY PRIVACY STATEMENT**

CO-OPERATORS LIFE INSURANCE COMPANY ("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.

**AUTHORIZATION AND ASSIGNMENT**

IN CONSIDERATION FOR ANY PAYMENT OF DISABILITY BENEFITS MADE TO ME BY CO-OPERATORS, 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 LIFE INSURANCE PROCEEDS TO THE PAYOR FOR SUCH PURPOSE.

I HEREBY AUTHORIZE ANY PHYSICIAN, HOSPITAL, CLINIC, PHARMACY OR ANY OTHER MEDICAL OR HEALTH CARE PROVIDER OR FACILITY, THE GROUP PLAN ADMINISTRATOR OR THEIR AGENTS, ANY INSURANCE COMPANY, REINSURER, PROVINCIAL HEALTH INSURANCE PLAN, GOVERNMENT DEPARTMENT OR AGENCY, MY EMPLOYER OR FORMER EMPLOYERS, AND ANY OTHER PERSON OR ORGANIZATION HAVING ANY MEDICAL, EMPLOYMENT, VOCATIONAL, FINANCIAL 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 ANY OR ALL OF THE FOLLOWING PURPOSES: TO INVESTIGATE AND CONFIRM 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.

I UNDERSTAND THAT MY REFUSAL OR WITHDRAWAL OF CONSENT MAY DELAY CLAIMS ADJUDICATION OR RESULT IN DENIAL OF MY CLAIM. I DECLARE THAT THE INFORMATION PROVIDED IN THIS EMPLOYEE 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.**

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*Employee Signature*

\_\_\_\_\_

*Date*

**PLEASE USE A SEPARATE SHEET FOR ADDITIONAL COMMENTS**