co-operators
Investments. Insurance. Advice.

PLAN MEMBER GUIDE AND APPLICATION FOR DISABILITY BENEFITS

DISABILITY BENEFITS

Disability benefits are intended to replace a portion of your salary during the period of time that you are unable to work due to an illness or injury.

You are not entitled to disability benefits automatically. Rather to qualify for disability benefits, we must determine that you are an eligible and covered plan member, you have submitted satisfactory proof of "total disability" as defined in your group insurance policy, you have completed an elimination period and you have met the terms and conditions of your group insurance policy.

Please check with your plan sponsor or your benefit booklet to confirm your elimination period as that determines when to submit your claim.

Elimination Period	When To Submit
Less than 60 days	Immediately after the date last worked
More than 60 days	Six weeks before the end of your elimination period

THE FOLLOWING INFORMATION IS REQUIRED:

Plan Member Statement
Asks general information about you, your occupation and the nature of your disability for the purpose of assessing your claim. Please complete all questions on this form and be sure to include your group number.

Attending Physician Statement
Ask your physician to complete the form. Ensure that your physician includes copies of test results, specialist 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 disability 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.

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

Proof of Identification
Government issued photo ID.

CLAIM INTERVIEW

A Co-operators Life Insurance Company representative may telephone you to obtain information about your occupation, education and employment history, medical history, and current condition.

CANADA PENSION PLAN/QUEBEC PENSION PLAN (CPP/QPP) DISABILITY BENEFITS

If you have already applied for CPP/QPP disability benefits, then please include your Notice of Entitlement with your application. If you have not applied, we may require you to submit an application for CPP/QPP benefits.

WORKERS' COMPENSATION BENEFITS

If you have applied for Workers' Compensation, we still require you to apply for disability benefits under your group insurance policy. This will ensure that your claim is received within the time limits prescribed in your group insurance policy.

AUTHORIZATION AND PRIVACY

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

Co-operators is committed to protecting the privacy, confidentiality, accuracy and security of the personal information it collects, uses, keeps and shares in the course of conducting business.

You can find more details about our privacy policy and how to contact our Privacy Officer at www.cooperators.ca/privacy.

CONTACT INFORMATION

If you have any questions or if you need help with your disability claim, please contact your plan administrator or our office at 1-866-442-3098.
Please have your group policy and certificate number available.

1900 ALBERT STREET REGINA SK S4P 4K8

co-operators
Investments. Insurance. Advice.

GROUP BENEFITS
DISABILITY BENEFITS
PLAN MEMBER STATEMENT

CONTACT INFORMATION

Mail: Co-operators Life Insurance Company
Disability Claims Department
1900 Albert Street
Regina, SK S4P 4K8

Fax: 1-866-889-9926

Email: disability_claims_admin@cooperators.ca

INSTRUCTIONS

To avoid delays, please complete the required information.

If illness/injury is claimed to be work related, you must make an application to Workers' Compensation in addition to this plan.

The completed form can be returned by email, fax, or the original can be mailed to the address provided.

PLAN MEMBER INFORMATION

Group _____ Account _____ Certificate _____

Plan Member _____ _____ _____
First Name Initial Last Name

Address _____ _____ _____ _____
Street City Province Postal Code

Phone Number (_____) _____ Cell Number (_____) _____

Date of Birth* _____ Sex ☐ M ☐ F ☐ X Height _____ Weight _____ Social Insurance Number** _____
MMM/DD/YYYY

*Enclose a copy of government issued photo ID. **Social Insurance Number is for taxable plans and any Contribution To Pension benefits.

Plan Sponsor/Employer _____ Phone Number (_____) _____

If you would like Co-operators to communicate with you by email about this disability claim, please provide your email _____

You acknowledge that data transmitted over the internet may be intercepted and that such transmission is at your own risk. If you no longer wish to communicate with Co-operators Life Insurance Company by email, please send notification to disability_claims_admin@cooperators.ca.

CLAIM INFORMATION

Describe your present medical condition, its cause and history:

Date Symptoms Began _____ Date of first treatment for this illness/injury _____
MMM/DD/YYYY MMM/DD/YYYY

Date last worked due to medical condition _____
MMM/DD/YYYY

Have you ever had a similar injury or illness in the past? ☐ Yes ☐ No

If yes, please describe your condition, the date of its onset, any treatment you received for it, and any time lost from work because of it:

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

Date _____ Time _____
MMM/DD/YYYY

Details

a) Was this a work related injury? ☐ Yes ☐ No

b) Was another party at fault? ☐ Yes ☐ No

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

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

e) Were any charges laid? ☐ Yes ☐ No

f) Are you pursuing a claim for wage loss against a third party? ☐ Yes ☐ No

Plan Member _____ _____ _____
First Name Initial Last Name

CLAIM INFORMATION (CONTINUED)

List all physicians you have seen for your present medical condition (ensure copies of all available specialists' reports are provided):

Physician	Address	Dates Seen From	Dates Seen To	Next Appointment Date
		_____ MMM/DD/YYYY	_____ MMM/DD/YYYY	_____ MMM/DD/YYYY
		_____ MMM/DD/YYYY	_____ MMM/DD/YYYY	_____ MMM/DD/YYYY
		_____ MMM/DD/YYYY	_____ MMM/DD/YYYY	_____ MMM/DD/YYYY

List any dates of hospitalization From _____ MMM/DD/YYYY To _____ MMM/DD/YYYY

Has your physician told you to restrict your activities in any way? ☐ Yes ☐ No

If yes, describe what they told you about restricting your activities

How do these restrictions interfere with your ability to perform your job duties?

Have you discussed a return to work with your employer? ☐ Yes ☐ No

☐ Own Occupation Date _____ MMM/DD/YYYY
☐ Modified Occupation Date _____ MMM/DD/YYYY
☐ Part-Time Date _____ MMM/DD/YYYY
☐ Full-Time Date _____ MMM/DD/YYYY

Have you discussed a return to work with your physician? ☐ Yes ☐ No

☐ Own Occupation Date _____ MMM/DD/YYYY
☐ Modified Occupation Date _____ MMM/DD/YYYY
☐ Part-Time Date _____ MMM/DD/YYYY
☐ Full-Time Date _____ MMM/DD/YYYY

OTHER INCOME

Have you applied for, or are you receiving the following:
(Attach copies of all correspondence you have received)

	I have applied	I am receiving	Date Applied	Effective Date	Amount
Workers' Compensation	☐ Yes ☐ No	☐ Yes ☐ No	_____ MMM/DD/YYYY	_____ MMM/DD/YYYY	$ _____ per week/bi-weekly
Canada Pension					
Retirement	☐ Yes ☐ No	☐ Yes ☐ No	_____ MMM/DD/YYYY	_____ MMM/DD/YYYY	$ _____ per month
Disability	☐ Yes ☐ No	☐ Yes ☐ No	_____ MMM/DD/YYYY	_____ MMM/DD/YYYY	$ _____ per month
Car Insurance	☐ Yes ☐ No	☐ Yes ☐ No	_____ MMM/DD/YYYY	_____ MMM/DD/YYYY	$ _____ per week/month
Employment Insurance	☐ Yes ☐ No	☐ Yes ☐ No	_____ MMM/DD/YYYY	_____ MMM/DD/YYYY	$ _____ per week/month
Other: _____ (please describe)	☐ Yes ☐ No	☐ Yes ☐ No	_____ MMM/DD/YYYY	_____ MMM/DD/YYYY	$ _____ per week/month

Plan Member _____ _____ _____
First Name | Initial | Last Name

OCCUPATION AND EDUCATION INFORMATION

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

WORK EXPERIENCE

Present Employment

Occupation _____ Date Started _____
MMM/DD/YYYY

Duties _____

Previous Employment
Please complete the following, providing details of your previous positions

1. Employer _____ Job Title _____ Dates of Employment _____

   Duties _____

2. Employer _____ Job Title _____ Dates of Employment _____

   Duties _____

3. Employer _____ Job Title _____ Dates of Employment _____

   Duties _____

Job Skills
What skills have you acquired in your current and previous jobs? (e.g. typing, operation of equipment, supervisory skills, etc).
Where appropriate, give level of proficiency.

Community Interests
Outline your past or present involvement with any community or volunteer organizations.

_____

Hobbies

_____

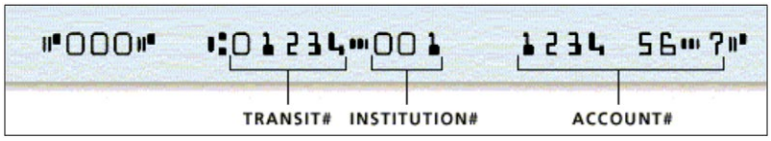
DIRECT DEPOSIT

To issue a payment, we require completion of this section. Banking information is not required for ASSIST files.

Direct deposit of funds allows Co-operators Life Insurance Company to deposit your disability benefits directly to your financial institution.
The funds will be deposited within 1 – 3 business days.

Financial Institution _____

Please include a personal cheque marked "VOID". If you are not attaching a void cheque, please provide the following information as displayed by the example below:



Transit _____ (5 digits) Institution _____ (3 digits) Account _____ (maximum 12 digits)

Plan Member _____ _____ _____
First Name | Initial | Last Name

PRIVACY

Co-operators Privacy Statement

At 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 your province of residence or 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 our privacy policy and how to contact our Privacy Officer at www.cooperators.ca/privacy.

PLAN MEMBER 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 authorize any physician, hospital, clinic, pharmacy or any other medical or health care provider or facility, the group plan administrator 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, employment, vocational , financial or other relevant personal information or records regarding me to release to and exchange with Co-operators Life Insurance Company, 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, 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.

In consideration for any payment of benefits made to me by Co-operators Life Insurance Company, 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 insurance proceeds to the payor for such purpose.

I hereby authorize Co-operators Life Insurance Company to deposit disability payments directly to my account and to exchange my relevant financial information with my financial institution for such purpose. This authorization shall remain valid for the duration of my claim unless revoked by me in writing.

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 Plan Member 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.

Plan Member Signature _____ Date _____
MMM/DD/YYYY