co-operators
Investments. Insurance. Advice.

PLAN MEMBER GUIDE AND APPLICATION FOR EARLY INTERVENTION SERVICES

Early Intervention Services

Early Intervention services are intended to assess your absence from work for the purposes of salary continuance and may include assisting with recovery and early return to work planning.

Please check with your plan sponsor to confirm when to submit your application.

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 absence. Please complete all questions on this form and be sure to include your group number.

Attending Physician Statement
Ask your physician to complete the Attending Physician Statement form specific to your primary diagnosis. There are two forms, one for mental health conditions and one for all other conditions. Ensure that your physician includes copies of test results, specialist reports and any additional information that may assist us with your application.

You are responsible for providing medical proof to support your absence from work. 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.

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, you must still submit your application for Early Intervention services. This will ensure that your application is received within the prescribed time limits.

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 revised privacy policy at www.cooperators.ca/privacy. If you have any questions regarding our privacy policy or about how we collect, use, keep and share your personal information, please contact our Privacy Officer at Co-operators at 1-888-887-7773, or by e-mail: privacy@cooperators.ca

Contact Information

If you have any questions or if you need help with this application, 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 EARLY INTERVENTION 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 _____
MMM/DD/YYYY

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

Medical condition has prevented me from working since _____
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 _____

Was this a work related injury? ☐ 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		Next Appointment Date
		From	To	
		_____ 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)

OCCUPATION INFORMATION

Present Employment

Occupation _____ Date Started _____ (MMM/DD/YYYY)

Duties _____

Previous Employment

If you have been in your current role less than 2 years, please provide details of your previous position.

Employer _____ Job Title _____ Dates of Employment _____

Duties _____

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 revised privacy policy at www.cooperators.ca/privacy. If you have any questions regarding our privacy policies or about how we collect, use, keep and share your personal information, please contact our Privacy Officer at Co-operators at 1-888-887-7773, or by e-mail: privacy@cooperators.ca.

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 acknowledge that Co-operators Life Insurance Company may provide supportive Early Intervention services to me prior to the date upon which I may, if at all, become eligible to receive Long Term Disability (LTD) benefits and that these services provided by Co-operators Life Insurance Company will not in any way be construed as an admission of liability by Co-operators Life Insurance Company or acceptance of a claim for the payment of LTD benefits.

I hereby authorize any physician, hospital, clinic or any other medical or health care provider or facility, the group plan administrator or its representatives, any insurance company, government agency or my employer to release to Co-operators Life Insurance Company or its representatives or agents, any and all medical, employment or vocational information or records regarding me for the following purposes: to provide early intervention services that may include the evaluation, administration and management of my medical absence from work, and to assess and facilitate my return to work. I further authorize Co-operators Life Insurance Company or its representatives or agents to disclose any such information obtained during the course of my early intervention file to any physician, clinic or any other medical or health care provider or facility for such purposes.

I understand that my refusal or withdrawal of consent may delay the provision or result in the denial of such services. I declare that the information provided in this authorization and any statements provided in any personal or telephone interview relating to this medical leave application are/will be true, complete and accurate.

In the event I do not return to work and I submit an application for Long Term Disability benefits, I understand and authorize that my entire Early Intervention file will form part of my Long Term Disability file.

This authorization shall remain valid for the duration of the provision of early intervention services unless revoked in writing by me. Any copy of this authorization shall be as valid as the original.

Plan Member Signature _____ Date _____
MMM/DD/YYYY