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Investments. Insurance. Advice.

GROUP BENEFITS
LONG TERM DISABILITY
PLAN SPONSOR 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.

For clients not billed by Co-operators, please attach a copy of the plan member's enrolment form and a copy of the billing.

If illness/injury is claimed to be work related, the plan member 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

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

Group _____ Account _____ Class _____ Certificate _____

Date of Birth _____ (MMM/DD/YYYY)

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

Phone Number (_____) _____ Cell 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.

COVERAGE INFORMATION

Class or union affiliation to which the plan member belongs (if applicable) _____

Date plan member became insured under Co-operators LTD policy _____ (MMM/DD/YYYY) **and** with a previous carrier's policy _____ (MMM/DD/YYYY)

Date of Employment _____ (MMM/DD/YYYY) Date Last Worked _____ (MMM/DD/YYYY) Date Returned to Work _____ (MMM/DD/YYYY)

Is condition due to injury or illness arising out of employment? ☐ Yes ☐ No

If "Yes", has the plan member applied for Workers' Compensation benefits? ☐ Yes ☐ No

If "No" please provide details. _____

The plan member is ☐ Hourly ☐ Salaried ☐ Commissioned***

*** For commissioned or self employed plan members provide T4, notice of assessment, and statement of expenses for the previous two years.

The plan member is ☐ Full-time ☐ Part-time ☐ Contract (please enclose a copy of the contract agreement)

Average hours worked in a normal work week _____ (excluding overtime) What days of the week does the plan member work? _____ (ie. Monday to Friday)

Is the plan member involved in shift work? ☐ Yes ☐ No If yes, what is the rotation schedule? _____

Date employment terminated (if applicable) _____ (MMM/DD/YYYY) Reason _____

EARNINGS/BENEFIT INFORMATION (ATTACH COPY OF PAY STUB FOR LAST FULL PAY PERIOD)

Plan Member Gross Salary $ _____ (exclude overtime, commissions, bonuses) ☐ Hourly ☐ Weekly ☐ Bi-weekly ☐ Semi-monthly ☐ Monthly ☐ Annually

Effective Date of Salary _____ (MMM/DD/YYYY) Is any portion of the premium paid by the plan sponsor/employer? ☐ No (non-taxable) ☐ Yes (taxable)

Current tax exception per Federal TD1 $ _____ (Attach TD1) (In Quebec, tax deductions are according to the latest TP-1015:3)

State regular payroll deductions for: Pension (if applicable) $ _____ RRSP (if applicable) $ _____

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

EARNINGS/BENEFIT INFORMATION (CONTINUED)

OTHER INCOME:

☐ Sick Pay	From _____ (MMM/DD/YYYY) To _____ (MMM/DD/YYYY)	☐ Vacation Pay	From _____ (MMM/DD/YYYY) To _____ (MMM/DD/YYYY)
☐ Workers Compensation	From _____ (MMM/DD/YYYY) To _____ (MMM/DD/YYYY) Status _____	☐ Employment Insurance	From _____ (MMM/DD/YYYY) To _____ (MMM/DD/YYYY) Status _____
☐ Short Term Disability	From _____ (MMM/DD/YYYY) To _____ (MMM/DD/YYYY) Status _____	☐ Other	From _____ (MMM/DD/YYYY) To _____ (MMM/DD/YYYY) Please explain _____

PENSION INFORMATION (IF APPLICABLE)

At the date of disability, was the plan member enrolled in one of the following plans? ☐ Yes ☐ No

☐ Defined Benefit Pension Plan ☐ Defined Contribution Pension Plan ☐ Group RRSP ☐ Individual RRSP

Administered by (financial institution or organization) _____

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

Date plan member became or will become eligible to contribute _____ (MMM/DD/YYYY)

Plan Name _____ Registration/Account Number _____

Contribution levels at date of disability Employee % _____ Employer % _____

OCCUPATIONAL INFORMATION

What was the regular occupation of the plan member immediately prior to his/her no longer attending work? _____

How long has the plan member worked in this position? _____

Please describe this plan member's regular occupation as well as any modifications, if any. **Attach a copy of the job description provided by the company.**

When did the plan member's illness or injury first appear to affect his/her work? _____ (MMM/DD/YYYY)

From your observations how did the plan member's performance change?

Are you able to accommodate modified: Hours ☐ Yes ☐ No Duties ☐ Yes ☐ No

Have you discussed a return to work with the plan member? ☐ Yes ☐ No If yes, provide date and details _____ (MMM/DD/YYYY)

Has this job been eliminated? ☐ Yes ☐ No

PHYSICAL DEMANDS ANALYSIS

The following physical demands analysis of the plan member's occupation is to be completed by his/her supervisor.
In the appropriate column, please specify the average amount of time (in hours) the following activities are regularly performed:

		Continuously	Daily Total
1. Sitting			
2. Standing			
3. Driving			
4. Bending			
5. Climbing up and down stairs			
6. Lifting	☐ 0-10 lbs ☐ 10-20 lbs ☐ 20-50 lbs ☐ 50+ lbs with lifting device? ☐ Yes ☐ No		
7. Pushing/ Pulling	☐ 0-10 lbs ☐ 10-20 lbs ☐ 20-50 lbs ☐ 50+ lbs		

Please describe work environment (i.e. temperature, noise levels, chemical/dust exposure, etc.)

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

OCCUPATIONAL INFORMATION (CONTINUED)

Please list any machines, tools, or other equipment that the plan member uses in the occupation

Please provide any additional information that may be relevant to this claim which has not been previously provided

DECLARATION

Name of Plan Sponsor _____

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

Name of Supervisor _____ Phone Number (_____) _____

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

Form completed by _____ (Name) Title _____

I hereby declare that the answers to the above questions are accurate and complete.

Authorized Signature _____ Date _____ (MMM/DD/YYYY)

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