the co-operators®
A Better Place For You®

ContinYou | GOLDEN

CONTINYOU® GOLDEN SURVIVING SPOUSE APPLICATION

To avoid delays, please complete the required information. Completed applications can be sent to:
continyou_golden@cooperators.ca or 1900 Albert Street, Regina, SK S4P 4K8 Attention: Group Benefits, Sales Support

1. RETIREE INFORMATION

Group **65000** Account _____ Certificate _____

Retiree _____ _____ _____ Date of Death _____
First Name Initial Last Name

2. SURVIVING SPOUSE INFORMATION

To qualify for the Surviving Spouse coverage, the application must be received no later than 60 days from the date of the Retiree's death.

Applicant _____ _____ _____
First Name Initial Last Name

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

Address _____ _____ _____ _____
Street City Province Postal Code

Home Phone Number (_____) _____ Cell Number (_____) _____ Work Phone Number (_____) _____

Email _____ Language of Preference ☐ English ☐ French

We use reasonable safeguards to protect all information collected, used, retained and disclosed in the course of conducting business; however, email may be vulnerable to interception by unauthorized parties. We discourage you from emailing personal or sensitive information. If you provided your email to us, or if you contacted us by email, we accept this as your consent to communicate with you by email. If you do not wish for us to communicate with you by email, please notify us at your earliest convenience.

3. SURVIVING DEPENDENT INFORMATION

These dependents are only eligible if they were covered under this plan as the Retiree's dependents

Dependent(s)

_____ _____ _____ Date of Birth _____ ☐ Male ☐ Female ☐ Student* ☐ Disabled**
First Initial Last MMM/DD/YYYY

_____ _____ _____ Date of Birth _____ ☐ Male ☐ Female ☐ Student* ☐ Disabled**
First Initial Last MMM/DD/YYYY

*You must notify The Co-operators if there are any changes in student status.
**You are required to complete a Group Health Evidence questionnaire once a disabled dependent reaches the dependent age maximum as listed in the certificate.

4. COVERAGE SELECTION

Please select the following:

Coverage Option ☐ Single ☐ Couple ☐ Family

5. OTHER INSURANCE COVERAGE

Include other personal or group plans that will continue to be in effect at the same time as ContinYou GOLDEN

Do any listed covered persons have additional coverage with another insurer? ☐ Yes ☐ No

If yes, complete the following:

Name of Covered Person	Insurance Company	Policy/Certificate #	Persons Covered	Coverage Type
			☐ Applicant ☐ Spouse/Common Law ☐ Dependent	☐ Health ☐ Dental ☐ Travel
			☐ Applicant ☐ Spouse/Common Law ☐ Dependent	☐ Health ☐ Dental ☐ Travel

6. PAYMENT SECTION – PRE-AUTHORIZED DEBIT (PAD) PLAN

I request and authorize The Co-operators to make withdrawals against the bank, credit union or trust company account specified, or any account subsequently named by me, and such banking institution to process these withdrawals as if I had signed them, for the purpose of collecting premiums under this policy.

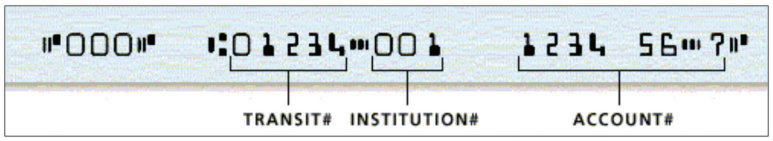
If the said account is replaced by an account in another banking institution, this request and authorization shall also apply to such other banking institution.

I have waived my right to receive pre-notification of the amount of the PAD and agreed that I do not require advance notice of the amount of the PADs before the debit is processed.

Financial Institution Name _____

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

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)

NOTE: the PAD withdrawals are the 1st of each month. The date the PAD cheque clears your account can be anywhere from one to ten days after the deduction date (this depends on the residence location of the payor and the clearing facility of each individual financial institution)

Your Payor's PAD agreement may be cancelled provided notice is received 14 days before the next scheduled PAD. If any of the above details are incorrect, please contact us immediately at 1-800-667-8164. If the details are correct, you do not need to do anything further and your Pre-Authorized Debits will be processed and start on the Payment Start Date indicated above. You have certain recourse rights if any debit does not comply with this agreement. For example, you have the right to receive reimbursement for any PAD that is not authorized or is not consistent with the terms of this PAD agreement. To obtain more information on your recourse rights, contact your financial institution or visit www.payments.ca. I hereby authorize The Co-operators to withdraw premium payments from my account for the policy referred to herein and to exchange my relevant financial information with my financial institution for such purpose. This authorization shall remain valid for so long as my coverage remains in effect unless revoked by me in writing. Any copy of this authorization shall be as valid as the original.

Bank Depositor Signature _____ Date _____ (MMM/DD/YYYY)

7. REQUEST FOR DIRECT DEPOSIT OF EXTENDED HEALTH AND DENTAL CLAIMS

Direct deposit of funds allows The Co-operators to deposit your benefit payments directly to your financial institution. This service is convenient for you because the money will automatically appear in your account each time a claim is paid. A corresponding explanation of benefit letter will be mailed to you explaining the distribution of the benefit payment. If you change your bank account, we require three weeks notice to avoid any delay in your payment.

To have your claim benefits deposited electronically, simply complete the following:

☐ Same as completed above in Section #6 – Payment Section – Pre-Authorized Debit (PAD) Plan

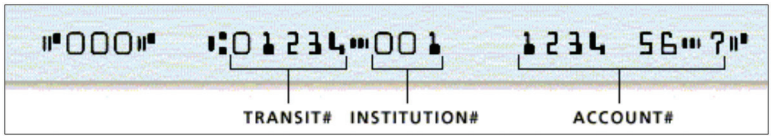
If you wish to receive electronic explanation of benefits emailed to you, log into Benefits Now for Plan Member and choose paperless

I hereby authorize The Co-operators to deposit Extended Health and Dental payments directly to my account and to exchange my relevant financial information with my financial institution for such purpose. This authorization shall remain valid until revoked by me in writing. Any copy of this authorization shall be as valid as the original.

Financial Institution Name _____

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

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)

8. PRIVACY STATEMENT

Co-operators Life Insurance Company Privacy Statement

At The 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 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 The Co-operators privacy policy at www.cooperators.ca. 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 The Co-operators at 1-888-887-7773, or by e-mail: privacy@cooperators.ca

9. DECLARATION & AUTHORIZATION

The Surviving Spouse declares and agrees that:

- I have read and understood the section entitled 'Privacy Statement' and consent to the collection, use and disclosure of my personal information for the purposes stated;
- I hereby apply for ContinYou® GOLDEN benefits coverage;
- I certify that all written statements and answers given in connection with this Application have been reviewed and are complete and true;
- I understand that my dependents and I must currently be covered under my Provincial health plan and remain covered in order to be eligible for this coverage;
- I authorize The Co-operators or their agents, or any other person or organization having any relevant information regarding me or dependents to release and exchange all information necessary for the purpose of determination of eligibility for benefits and administration of the benefits plan;
- I am authorized to act on behalf of my dependents for such purposes;
- The coverage will have an effective date as determined by The Co-operators;
- Acceptance of any Policy issued pursuant to this Application will constitute agreements to its terms and conditions;
- Any copy of this authorization shall be as valid as the original.

Surviving Spouse Signature _____ Date _____
MMM/DD/YYYY

HEAD OFFICE USE ONLY

☐ Eligibility Confirmed Effective Date of Coverage _____
MMM/DD/YYYY

Welcome Package Distribution _____ Account _____ Certificate _____