the co-operators®
A Better Place For You®

GROUP BENEFITS
PERSONAL SPENDING ACCOUNT CLAIM FORM

INSTRUCTIONS

- Please print clearly and be sure to complete all sections of your Personal Spending Account claim form
- Attach the **original** receipt for each expense claimed and retain a copy for your records
- Since all expenses are taxable benefits to the plan member, all claims under the Personal Spending Account are processed under the plan member

MAILING INSTRUCTIONS

Mail your completed form to:
Co-operators Life Insurance Company - Extended Health Care Claims
1920 College Avenue Regina, SK S4P 1C4

DIRECT DEPOSIT AND ELECTRONIC CLAIM STATEMENT

You will receive your claim payments faster with direct deposit and enjoy the convenience of seeing your claim statements online.

Sign up for direct deposit and electronic claim statements by calling our Client Service Centre at 1-800-667-8164 or signing in to Benefits Now®.

PART 1 - PLAN MEMBER INFORMATION

Group ______________ Account ________________ Certificate ____________________ Plan Sponsor/Employer ______________________________

Plan Member ________________________________ (First Name) ______ (Initial) ____________________________________ (Last Name) Date of Birth _________________________ (MMM/DD/YYYY)

Address ____ (Street) _________________________________ (City) _________ (Province) ____________ (Postal Code)

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

Co-operators Life Insurance Company uses reasonable safeguards to protect all information it collects, uses, retains and discloses in the course of conducting business. However, the internet is not a secure medium and we do not use email encryption. As such, we cannot guarantee complete privacy and confidentiality of any email transmissions. This includes the email text and any attachments. By authorizing communication by email, you are acknowledging that you have read and understood this notice and disclaimer and are consenting to the transmission of your personal information using email knowing the email and any attachments may be subject to unauthorized access, use or disclosure by third parties. You agree that Co-operators Life Insurance Company is not responsible or liable for any damages or losses you or any other person may suffer as a result of any breach of privacy, confidentiality or security by transmission of your personal information using email communication. If you no longer wish to communicate with Co-operators Life Insurance Company by email, please send notification to Health_Support_Representatives@cooperators.ca

PART 2 - CLAIM INFORMATION

Attach original receipts and ensure each receipt clearly indicates the type of expense being claimed

Expense Description	Date of Service MMM/DD/YYYY	Amount Claimed
	Total Amount Claimed	$

Who and what is covered may vary according to the coverage available under your group benefit plan, depending on choices made by your employer. To find out more, please refer to your employee booklet. All reimbursed claims will be treated as a taxable benefit to the plan member.

PART 3 - PLAN SPONSOR AUTHORIZATION (ONLY IF REQUIRED)

Employment Date __________________ (MMM/DD/YYYY) Employee's/Member's Effective Date ____________________ (MMM/DD/YYYY)

Termination Date (if applicable) __________________ (MMM/DD/YYYY) Retirement Date __________________ (MMM/DD/YYYY)

Signature of Authorized Official ____ Date _________________________ (MMM/DD/YYYY)

PART 4 - PRIVACY AND AUTHORIZATION

Co-operators Life Insurance Company Privacy Statement
Co-operators Life Insurance Company 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.

I certify that the information contained herein is true, complete and accurate and that each of the listed expenses relate to lifestyle or wellness-related services purchased and/or incurred by the above-named individuals. I acknowledge that the submission of false or incomplete information may result in the delay or denial of this claim. I authorize any physician, dentist or any health care provider and/or facility, any insurance company, benefit service provider and any other person or organization having any medical or other relevant personal information regarding me or my spouse and/or dependent to release to and exchange with Co-operators Life Insurance Company, the group plan administrator or their representatives and/or agents any and all information necessary to investigate and confirm the accuracy and validity of this claim, determine eligibility for benefits and/or administer the claim and group benefits plan. I confirm that I am authorized to act on behalf of my spouse and/or dependents for such purposes. Any copy of this authorization shall be as valid as the original.

In the event there is suspicion and/or evidence of fraud and/or plan abuse concerning this claim, I acknowledge and agree that Co-operators Life Insurance Company may investigate and that information about me, my spouse and/or dependents pertaining to this claim may be used and disclosed to any relevant organization including regulatory bodies, government organizations, medical suppliers, and other insurers, and where applicable my Plan Sponsor, for the purpose of investigation and prevention of fraud and/or plan abuse.

If Co-operators Life Insurance Company pays me an amount that exceeds the benefit(s) to which I am entitled under my plan (the Overpayment Amount), then I acknowledge and agree that: (a) I am indebted to Co-operators Life Insurance Company for the Overpayment amount (b) Co-operators Life Insurance Company has the right to recover the Overpayment Amount through any means available by law, and (c) Co-operators Life Insurance Company will offset any benefits payable to me by the Overpayment Amount until Co-operators Life Insurance Company has recovered the Overpayment Amount in full.

Plan Member Signature ____ Date _________________________ (MMM/DD/YYYY)