

To avoid delays, please complete the required information by printing clearly in ink.

MAILING ADDRESS

Mail: Co-operators Life Insurance Company
Group Benefits Administration
1900 Albert Street
Regina, SK S4P 4K8

Phone: 1-800-667-8164

Fax: (306) 761-7176

1. PLAN MEMBER INFORMATION

Group _____ Account _____ Group Name _____

Plan Member _____
First Name Initial Last Name

Occupation _____ Hire Date _____
MMM/DD/YYYY

Reason for request _____

1. Did you have coverage with another insurance company prior to your date of hire with the current employer? Yes No
2. What was the name of your previous insurer? _____
3. State the period of time that you were insured by this company _____ to _____
MMM/DD/YYYY MMM/DD/YYYY
4. What coverage did you have under your previous plan? _____
(ie. Life insurance, AD&D, Extended Health, Dental Care, Long Term Disability, etc)
 If yes, please list: _____

2. PRIVACY & SIGNATURE

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

I hereby apply for waiver of the waiting period as required under the group policy of insurance. I declare that the information contained herein is true, complete and accurate and understand that the submission of false or incomplete information may result in denial of coverage or the delay or denial of any claim. I understand such information is necessary to determine eligibility for coverage, adjudicate all claims and administer the group benefits plan. Any copy of this authorization shall be as valid as the original.

Signature _____ Date _____
(Plan Member's Signature) MMM/DD/YYYY

Signature _____ Date _____
(Employer's Signature) MMM/DD/YYYY

Retain a copy for your records.