

# CONTINYOU<sup>®</sup> GOLDEN RETIREE PLAN APPLICATION GROUP 65000

To avoid delays, please complete the required information. Completed applications can be sent to:  
continyou\_golden@cooperators.ca or 1920 College Avenue, Regina, SK S4P 1C4 Attention: Group Benefits, Sales Support

## 1. RETIREE INFORMATION

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.

## 2. ADDITIONAL INDIVIDUALS TO BE COVERED

Extended Health Care coverage for a dependent who is hospitalized on the date they become eligible for coverage, other than a newborn child, will be delayed until the first day immediately following discharge from the hospital.

### Spouse/Common Law

\_\_\_\_\_  
First Initial Last Date of Birth \_\_\_\_\_  Male  Female  
MMM/DD/YYYY

### Dependent(s)

\_\_\_\_\_  
First Initial Last Date of Birth \_\_\_\_\_  Male  Female  Student\*  Disabled\*\*  
MMM/DD/YYYY

\_\_\_\_\_  
First Initial Last Date of Birth \_\_\_\_\_  Male  Female  Student\*  Disabled\*\*  
MMM/DD/YYYY

\*You must notify The Co-operators if there are any changes in student status. You must verify your child's student status by submitting confirmation of enrolment by June 15th each year.  
 \*\*You are required to complete a Group Health Evidence questionnaire once a disabled dependent reaches the dependent age maximum as listed in the certificate.

## 3. PRIOR PLAN INFORMATION

To qualify for ContinYou<sup>®</sup> GOLDEN coverage, the application must be received by The Co-operators no later than 60 days from the date on which the applicant's prior Group Benefits coverage ended.

Name of Employer \_\_\_\_\_ Name of Insurance Company \_\_\_\_\_

Policy Number \_\_\_\_\_ Certificate Number \_\_\_\_\_ Expiry Date of Coverage \_\_\_\_\_  
MMM/DD/YYYY

Benefits Provided under Prior Plan  Extended Health  Dental

## 4. COVERAGE SELECTION

Please select the following:

### Coverage Option

Single  Couple  Family

### Extended Health Care and Dental Plan Option

Includes 15 days Emergency Travel  
Medical Coverage

Base  Enhanced  Enhanced Plus

Monthly Premium \$ \_\_\_\_\_

### Emergency Out of Country Medical Benefit

30 Days  60 Days  90 Days

Monthly Premium \$ \_\_\_\_\_

Total Monthly Cost\* \$ \_\_\_\_\_

\* Does not include provincial/federal tax(s), if applicable

**NOTE: Changes to coverage cannot be upgraded at a later date. After a minimum 3 year participation in your plan option, you may downgrade at renewal. Refer to the Rate Page for the corresponding premium amounts**

## 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   |
|------------------------|-------------------|----------------------|--|---|
|                        |                   |                      | <input type="checkbox"/> Applicant<br><input type="checkbox"/> Spouse/Common Law<br><input type="checkbox"/> Dependent | <input type="checkbox"/> Health<br><input type="checkbox"/> Dental<br><input type="checkbox"/> Travel |
|                        |                   |                      | <input type="checkbox"/> Applicant<br><input type="checkbox"/> Spouse/Common Law<br><input type="checkbox"/> Dependent | <input type="checkbox"/> Health<br><input type="checkbox"/> Dental<br><input type="checkbox"/> 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.

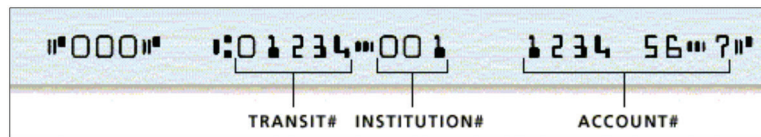
If the said account is replaced by an account in another banking institution, this request and authorization shall also apply to such other banking institution.

**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](http://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

