the co-operators®
A Better Place For You®

ContinYou® | GOLDEN

CONTINYOU® GOLDEN CHANGE FORM

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. GENERAL INFORMATION

Effective Date of Change _____ (MMM/DD/YYYY) Group **65000** Account _____ Certificate _____

Applicant _____ (First Name) _____ (Middle) _____ (Last Name)

2. RETIREE INFORMATION

☐ Change Name, Address, Contact Information

Name _____ (First Name) _____ (Initial) _____ (Last Name)

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

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

Email _____

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. 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.

☐ Remove **Spouse/Common Law**

_____ (First) _____ (Initial) _____ (Last) Date of Birth _____ (MMM/DD/YYYY) ☐ Male ☐ Female

☐ Remove **Dependent(s)**

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

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

*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.

4. COVERAGE SELECTION

☐ Change Coverage Selection

Please select the following:

Coverage Option ☐ Single ☐ Couple ☐ Family

Extended Health Care and Dental Plan Option ☐ Base ☐ Enhanced ☐ Enhanced Plus
Includes 15 days Emergency Travel Medical Coverage
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

☐ Additional coverage is being removed ☐ Additional coverage is being added - 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

☐ Change Pre-Authorized Debit (PAD) Plan details

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.

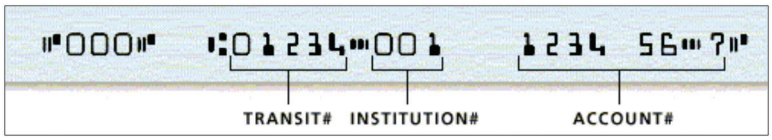
If the said account is replaced by an account in another banking institution, this request and authorization shall also apply to such other banking institution.

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 Co-operators Life Insurance Company ("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

☐ Change Direct Deposit details

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

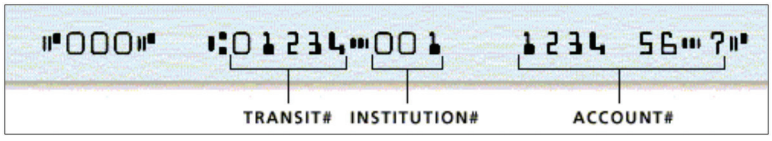
If you wish to receive electronic explanation of benefits emailed to you, log into Benefits Now for Plan Member and choose paperless.

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

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.

At The Co-operators, we recognize and respect the importance of privacy. When you enrol for insurance coverage or submit a claim, we establish a confidential file and collect, use and disclose your personal information for the purposes of issuing, administering, adjudicating and/or servicing your insurance. 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 persons we have authorized who have a need to know it to perform their duties. Our systems and procedures are designed to prevent the loss, misuse, unauthorized access, disclosure, alteration, or destruction of your information. Our commitment to security extends to the contracts and agreements we sign with external suppliers and service providers. We may store or process your personal information in Canada, the United States or other countries for processing, storage, analysis or disaster recovery and, under applicable law, governments, courts, law enforcement or regulatory agencies, may, by lawful order, obtain disclosure of your personal information. 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 the collection, use and disclosure of your personal information, please contact our Privacy Officer at The Co-operators at Priory Square, Guelph, ON, N1H 6P8, Tel: 1-888-887-7773, E-mail: privacy@cooperators.ca (please include The Co-operators company you deal with in your inquiry).

If you do not agree with our use and disclosure of your information in connection with your application and servicing any policy that we issue, we will not be able to offer you the insurance product you are interested in, service your insurance or adjudicate your claim.

9. DECLARATION & AUTHORIZATION

The Applicant 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 am or have been covered under a group health and dental plan indicated above within the last 60 days and was insured for a minimum of 2 years;
- 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, my spouse 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 spouse and/or 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.

Applicant Signature _____ Date _____
MMM/DD/YYYY

HEAD OFFICE USE ONLY

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

Welcome Package Distribution _____ Account _____ Certificate _____