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A Better Place For You®

GROUP BENEFITS CRITICAL ILLNESS CLAIMANT STATEMENT

This guide is designed to assist you in the claim submission process.

CO-OPERATORS LIFE INSURANCE COMPANY
1920 COLLEGE AVENUE REGINA SK S4P 1C4

GROUP BENEFITS
CRITICAL ILLNESS
CLAIMANT STATEMENT

CRITICAL ILLNESS BENEFITS

Critical Illness Benefits can be used to offset uninsured medical expenses, provide home renovations for wheelchair accessibility, provide nursing care, help with ongoing responsibilities/payments such as childcare, mortgage loan payments, etc.

Any Critical Illness Benefit deemed payable is payable to the Plan Member.

You are not entitled to Critical Illness Benefits automatically. To qualify for benefits, we must determine that:

- Your Group contract provides coverage for the specified illness/condition claimed;
- You have submitted satisfactory proof of the covered condition as defined in your Group contract;
- You have completed a survival period (as defined in the covered condition); and
- You have met the terms and conditions in your Group contract.

Please refer to your Group Contract to confirm coverage for the condition claimed.

THE FOLLOWING INFORMATION IS REQUIRED

Plan Sponsor Statement

Ensure the Plan Sponsor Statement is submitted to our office by your employer.

Claimant Statement

Asks general information about you, your condition and the nature of your symptoms and treatment for the purpose of assessing your claim. Please complete all questions on this form and be sure to include your Group and Account Number.

Physician Statement

Ask the specified physician to complete the form. Ensure that the physician includes copies of office records, investigations, consultation reports and any additional medical information that may assist us with your claim.

You are responsible for providing medical proof that you are entitled to receive Critical Illness Benefits. Your physician may request a fee for completing claim forms which will be your responsibility. If we request information directly from your physician, we may offer to pay your physician a correspondence fee.

CLAIM INTERVIEW

An insurance company representative may telephone you to obtain information about your medical history and current condition.

AUTHORIZATION AND PRIVACY

We need your permission to obtain information that will help us assess your claim. By signing the authorization request, you give us permission to obtain this information from your treatment providers, other insurers and hospitals where you received treatment.

Co-operators Life Insurance Company is committed to protecting the privacy, confidentiality, accuracy and security of the personal information it collects, uses, retains and discloses in the course of conducting business.

Co-operators Life Insurance Company will abide by all federal and provincial privacy legislation which governs the protection of all personal information in its custody. For further information regarding Co-operators Life Insurance Company privacy policies, please refer to our website at www.cooperators.ca.

CONTACT INFORMATION

If you have any questions or if you need help with your Critical Illness claim, please contact us at 1-866-442-3098. Please have your Group and Account number available.

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GROUP BENEFITS CRITICAL ILLNESS CLAIMANT STATEMENT

MAILING ADDRESS

Mail: Co-operators Life Insurance Company
Life Claims Department
1920 College Avenue
Regina SK S4P 1C4

Phone: 1-866-442-3098 Fax: 1-866-889-9925

INSTRUCTIONS

Please print clearly and be sure all sections are complete to avoid delays in processing the claim.

The completed form can be faxed to the number provided or the original can be mailed to the address provided.

Condition claimed may or may not be covered under your Policy. **Please refer to your Group Contract to confirm coverage for the condition claimed.**

1. PLAN MEMBER INFORMATION

Group ____________________ Account ____________________ Certificate ____________________

Name ____________________ (First Name) ________ (Initial) ____________________ (Last Name) Date of Birth ____________________ (MMM/DD/YYYY)

Address ____________________ (Street) ____________________ (City) ________ (Province) ____________ (Postal Code)

Phone (________) ____________________

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 Group_life_claims@cooperators.ca.

2. CLAIMANT INFORMATION (TO BE COMPLETED IF DIFFERENT THAN THE PLAN MEMBER)

☐ Spouse ☐ Dependent Child

Claimant ____________________ (First Name) ________ (Initial) ____________________ (Last Name) Date of Birth ____________________ (MMM/DD/YYYY)

Address ____________________ (Street) ____________________ (City) ________ (Province) ____________ (Postal Code)

Phone (________) ____________________

3. MEDICAL INFORMATION

1. Indicate the diagnosis provided:

____

____

____

2. Date of Diagnosis ____________________ (MMM/DD/YYYY)
3. Date insured was Advised of Diagnosis ____________________ (MMM/DD/YYYY)
4. Name and address of the physician who provided the diagnosis:

____

____

____

5. Was this physician the insured's regular family doctor? ☐ Yes ☐ No

   If no, who made the referral to this physician? ____________________

   Please provide the full name and address of the referral physician as well as the regular family physician:

   ____

   ____

6. Please list the symptoms that led to the first consultation for this illness. Please state the onset date and severity of each symptom:

Symptom	Onset Date MMM/DD/YYYY	Severity

3. MEDICAL INFORMATION (CONTINUED)

7. Date a Physician was first consulted regarding this illness ______________________
MMM/DD/YYYY

8. Name and address of physician first consulted:

____
____
____

9. Date Treatment Began ______________________
MMM/DD/YYYY

10. Please provide details of the current treatment, including dates and details of any hospital investigations or in-patient treatment:

____
____
____

11. Has there been a referral to any treatment facility, specialized medical facility or care provider for on-going care? ☐ Yes ☐ No

If yes, please indicate where:

____
____
____

12. Has the insured previously suffered from a similar or related illness? ☐ Yes ☐ No

If yes, please provide details and dates:

____
____
____

13. Have any blood relatives suffered from a similar or related illness? ☐ Yes ☐ No

If yes, state the relationship of relative, nature of illness and the age at which the illness was diagnosed:

____
____
____

14. Does the insured currently use or have they ever used any form of tobacco, marijuana, nicotine products or nicotine substitute (nicotine products including cigarettes, cigarillos, cigars, pipes, chewing tobacco, snuff, nicotine gum or patch or any other nicotine products)? ☐ Yes ☐ No

If yes, which substance(s) are or were used? ____

What quantity or number are or were used per day? ______________________________ Date last used ______________________
MMM/DD/YYYY

15. Please provide names and addresses for all treating physicians or hospitals at which treatment was received for this illness (include dates and reasons attended):

____
____
____

4. AUTHORIZATION

I hereby authorize any physician, hospital, clinic, pharmacy or any other medical or health care provider or facility, the group plan administrator and/or adjudicator or their agent, any insurance company, reinsurer, provincial health insurance plan, government department or agency, my employer or former employers, and any other person, organization or institution having any medical or other relevant personal information or records regarding me to release to and exchange with The Co-operators, the group plan administrator or their representatives and/or agents, any and all such information necessary for the purposes of investigating and confirming the accuracy and validity of my claim, to determine my eligibility for benefits or to administer my claim. I authorize the use of my Social Insurance Number for the purposes of tax reporting and for the identification and administration of any benefits. I understand that my refusal or withdrawal of consent may delay claims adjudication or result in the denial of my claim. I declare that the information provided in this statement and any statements provided in any personal or telephone interview relating to this claim are/will be true, complete and accurate. This authorization shall remain valid for the duration of the claim unless revoked in writing by me. Any copy of this authorization shall be as valid as the original.

Signed at ______________________________ this __________ day of ______________________ 20 __________
City, Province — Date — Month — Year

______________________________ ______________________________ Relationship to Claimant ______________________
Name of Plan Member — Signature of Plan Member

______________________________ ______________________________
Name of Claimant* — Signature of Claimant*

* Required when the Plan Member and Claimant are different persons and when the claimant is over age 16.

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5. PRIVACY STATEMENT

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The Co-operators 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.