the co-operators®
A Better Place For You®

GROUP BENEFITS CRITICAL ILLNESS PLAN SPONSOR STATEMENT

MAILING ADDRESS

Mail: Co-operators Life Insurance Company
Group 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.

For clients not billed by The Co-operators, please attach a copy of the plan member's enrolment form and a copy of the billing.

If the sum insured is based on salary, please attach a copy of the plan member's pay stub for the last full pay period.

1. PLAN MEMBER INFORMATION

Plan Member _____ (First Name) _____ (Initial) _____ (Last Name)

Group _____ Account _____ Certificate _____

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

Date of Employment _____ (MMM/DD/YYYY) Date Last Worked _____ (MMM/DD/YYYY) Date Returned to Work _____ (MMM/DD/YYYY)

Has the plan member been off work due to illness in the last 24 month period? ☐ Yes ☐ No

If yes, please provide reason _____

Plan Member occupation as of date last worked _____

Class or union affiliation to which the plan member belongs (if applicable) _____

The plan member is ☐ Hourly ☐ Salaried ☐ Commissioned The plan member is ☐ Full-time ☐ Part-time

2. EARNINGS/BENEFIT INFORMATION (ATTACH COPY OF PAY STUB FOR LAST FULL PAY PERIOD)

Plan Member Gross Salary $ _____ (exclude overtime, commissions, bonuses) ☐ Hourly ☐ Weekly ☐ Bi-weekly ☐ Semi-monthly ☐ Monthly ☐ Annually

Effective Date of Salary _____ (MMM/DD/YYYY)

3. DECLARATION

Name of Plan Sponsor _____

Phone Number (_____)_____ Cell Number (_____)_____ Fax Number (_____) _____

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 Group_life_claims@cooperators.ca.

Form completed by _____ (Name (please print)) Title _____

I hereby declare that the answers to the above questions are accurate and complete.

Authorized Signature _____ Date _____ (MMM/DD/YYYY)

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.