

MAILING ADDRESS

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

Fax: 1-866-889-9925

INSTRUCTIONS

The plan member is responsible for the cost of completing this form.
Medical Information is to be completed by the physician providing treatment.

1. PLAN MEMBER INFORMATION & AUTHORIZATION (TO BE COMPLETED BY THE PLAN MEMBER)

Plan Member _____
First Name Initial Last Name

Group _____ Account _____ Certificate _____

Plan Sponsor/Employer Name _____ Telephone Number (_____) _____

Date of Birth _____
MMM/DD/YYYY

I hereby authorize my physician to release any medical information supporting my claim for disability benefits to the plan administrator, the plan adjudicator and my insurer. I understand that I am responsible for obtaining this form and for any amounts charged by my physician to complete this form.

Plan Member Signature _____ Date _____
MMM/DD/YYYY

2. MEDICAL INFORMATION (TO BE COMPLETED BY THE PHYSICIAN)

Please attach copies of chart notes, test results, and consultation reports.

1. Diagnosis _____ Date of Diagnosis _____
MMM/DD/YYYY

2. If an accident _____
MMM/DD/YYYY

Nature of injury (location and extent) _____

Date of first treatment for this injury _____
MMM/DD/YYYY

3. Dismemberment Hand Foot Arm Leg Finger
If applicable, please use diagram indicating loss and level of amputation.

Date of amputation _____
MMM/DD/YYYY

Was amputation necessary as a result of the accident/disease indicated above? Yes No

4. Loss of use Hand Arm Foot Leg Paraplegia Hemiplegia Quadriplegia
Did the accident/disease result in total and irrecoverable loss of use/paralysis? Yes No

If yes, provide details _____

Has the loss of use/paralysis been continuous for 12 months? Yes No

5. Loss of Vision Speech Hearing
Percentage of loss _____%

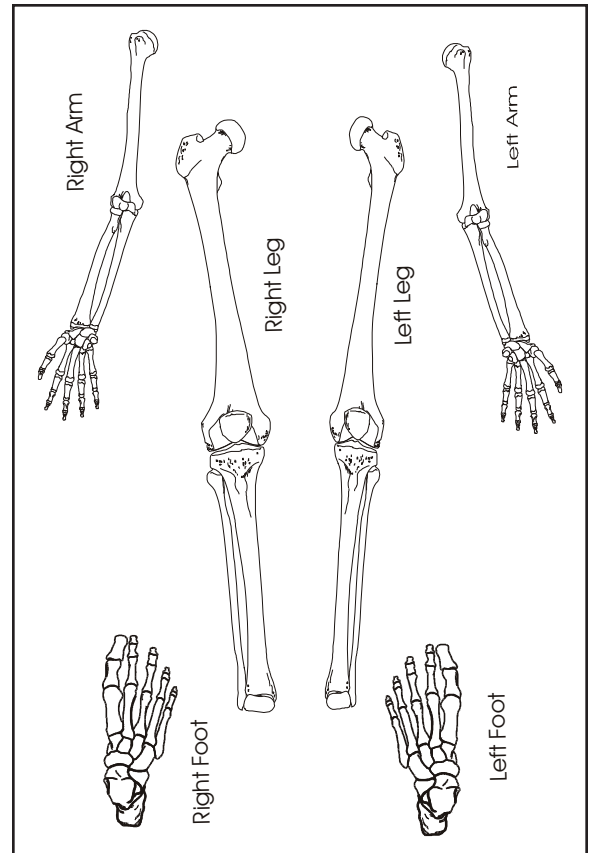
Will vision, speech or hearing be recovered or partially recovered by the use of a device or rehabilitative program? Yes No

If yes, provide details _____

Date on which loss of sight occurred _____ If accident/disease required removal of eye, date _____
MMM/DD/YYYY MMM/DD/YYYY

Vision in each eye prior to accident/disease: Right _____ Left _____ Present vision, if any, in each eye: Right _____ Left _____

6. Was the accident/disease described above solely responsible for the loss? Yes No
If no, provide details of any contributing cause(s) _____



3. PHYSICIAN ACKNOWLEDGEMENT AND AUTHORIZATION

I acknowledge that the information in this statement will be kept in a disability benefits file with the plan insurer and might be accessible by the patient or third parties to whom access has been granted or those authorized by law. By providing the information I consent to such unedited release by any information contained herein.

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.

Attending Physician (Please Print) _____

Address _____
Street City Province Postal Code

Certified Speciality _____ Family Physician Yes No

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

Physician Signature _____ Date _____
MMM/DD/YYYY

Physician's Stamp

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.