

## MAILING ADDRESS

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

Fax: 1-866-889-9925

## PLAN SPONSOR INSTRUCTIONS

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 SPONSOR

Plan Member \_\_\_\_\_  
First Name Initial Last Name

Group \_\_\_\_\_ Account \_\_\_\_\_ Certificate \_\_\_\_\_

Date of Birth \_\_\_\_\_  
MMM/DD/YYYY

Date plan member became insured under The Co-operators AD&D policy \_\_\_\_\_ **and** with a previous carrier's policy \_\_\_\_\_  
MMM/DD/YYYY MMM/DD/YYYY

Date of Employment \_\_\_\_\_ Date Last Worked \_\_\_\_\_ Date Returned to Work \_\_\_\_\_  
MMM/DD/YYYY MMM/DD/YYYY MMM/DD/YYYY

Is condition due to injury or illness arising out of employment?  Yes  No

If "Yes", has the plan member applied for Workers' Compensation benefits?  Yes  No

Provide any additional information which might assist us in considering this claim \_\_\_\_\_

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](mailto:Group_life_claims@cooperators.ca).

Form completed by \_\_\_\_\_ Title \_\_\_\_\_  
Name (please print)

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

Authorized Signature \_\_\_\_\_ Date \_\_\_\_\_  
MMM/DD/YYYY

## 2. PLAN MEMBER

Loss for which you are claiming \_\_\_\_\_

Is loss due to:

**Disease** Date of Diagnosis \_\_\_\_\_  
MMM/DD/YYYY

**OR**

**Accident** Date of Accident \_\_\_\_\_ Time \_\_\_\_\_  a.m.  p.m. Location of Accident \_\_\_\_\_  
MMM/DD/YYYY City Province

Describe the circumstances surrounding the accident \_\_\_\_\_  
 \_\_\_\_\_

Was alcohol involved in the events surrounding your accident?  Yes  No

Did the accident involve another party?  Yes  No If yes, provide the name of the other party/parties involved in the accident

Name \_\_\_\_\_ Address \_\_\_\_\_

Name \_\_\_\_\_ Address \_\_\_\_\_

Was it reported to the police?  Yes  No If yes, attach a copy of the police report.

Were any charges laid?  Yes  No If yes, against whom? \_\_\_\_\_

What were the charges? \_\_\_\_\_

Plan Member \_\_\_\_\_  
First Name Initial Last Name

**2. PLAN MEMBER (CONTINUED)**

List dates of hospitalizations from \_\_\_\_\_ to \_\_\_\_\_. Name of Institution \_\_\_\_\_  
MMM/DD/YYYY MMM/DD/YYYY

Provide names and addresses of attending physician(s)

Physician	Address	Date Seen
		_____
		_____
		_____

**3. PLAN MEMBER AUTHORIZATION**

**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.

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 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.

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Plan Member Signature \_\_\_\_\_ Date \_\_\_\_\_  
MMM/DD/YYYY

Address \_\_\_\_\_  
Street City Province Postal Code

Telephone (\_\_\_\_\_) \_\_\_\_\_