the co-operators®
A Better Place For You®

GROUP BENEFITS EMERGENCY OUT OF COUNTRY CLAIM AND AUTHORIZATION FORM

INSTRUCTIONS

British Columbia and Manitoba residents: If you have paid for expenses, please submit the original receipts to your provincial plan for initial reimbursement. Any outstanding balance can be submitted to Co-operators Life Insurance Company for consideration.

All Other Provinces: Please provide original receipts and ensure all sections of the claim form are complete because Co-operators Life Insurance Company has the authorization to submit this information on your behalf.

Mail your completed form to:
Co-operators Life Insurance Company
Extended Health Care Claims
1920 College Avenue
Regina, SK S4P 1C4

DIRECT DEPOSIT AND ELECTRONIC CLAIM STATEMENT

You will receive your claim payments faster with direct deposit and enjoy the convenience of seeing your claim statements online.

Sign up for direct deposit and electronic claim statements by calling our Client Service Centre at 1-800-667-8164 or signing in to Benefits Now™.

1. PLAN MEMBER INFORMATION

Group _____ Account _____ Certificate _____ Plan Sponsor/Employer _____

Plan Member _____ (First Name) ____ (Initial) _____ (Last Name) Date of Birth _____ (MMM/DD/YYYY)

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

2. PATIENT INFORMATION (PLEASE COMPLETE A SEPARATE FORM FOR EACH PERSON)

Patient _____ (First Name) ____ (Initial) _____ (Last Name) Date of Birth _____ (MMM/DD/YYYY)

Provincial Health Number _____ Relationship to Plan Member _____

Reason for Travel ☐ Vacation ☐ School ☐ Business ☐ Treatment

Date of Departure _____ (MMM/DD/YYYY) Date of Intended Return _____ (MMM/DD/YYYY) Date of Actual Return _____ (MMM/DD/YYYY)

Name of Canadian Physician _____ Phone Number (_____) _____

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

3. CO-ORDINATION OF BENEFITS

If you have other coverage where these expenses may be eligible (including spousal coverage through another Group Benefits plan, credit card coverage, motor vehicle insurance, trip cancellation and/or trip interruption) please complete this section.

Other Source (Name of Insurance Company/credit card etc) _____ Policy _____

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

Name of Cardholder _____

Has claim been submitted to this source? ☐ Yes ☐ No

4. INFORMATION ABOUT THE OCCURRENCE

Location of Occurrence _____ (City) _____ (Country) Total Amount Claimed and Currency _____

Have you already paid the provider for this service? ☐ Yes ☐ No

If a discount was received, please provide original discounted bills/invoices for processing

Describe the illness or injury (list all conditions, onset of illness in detail including diagnosis) _____

Was another party responsible for your illness or injury? ☐ Yes ☐ No

5. DIRECTION AND AUTHORIZATION TO PHYSICIANS, HOSPITALS AND OTHER MEDICAL PROVIDERS

By signing this form, I hereby authorize and direct any and all physician, hospital, clinic, facility or any other medical or health care provider, the group plan administrator and/or adjudicator or their agent or representative, any insurance company, reinsurer, provincial health insurance plan, government department or agency, and any other person, organization, association or institution having any medical or other relevant personal information regarding me or my spouse and/or dependent to disclose, release, share and exchange information with Co-operators Life Insurance Company, the group plan administrator and/or adjudicator or their agent or representative any and all such information necessary for the purposes of determining my eligibility, assessing my application, investigating and confirming the accuracy and validity of my claim, and administering or processing my claim. I am authorized to act on behalf of my dependants for these purposes. The authorization and direction I provided herein shall be good and sufficient authority, and any copy of this completed form is as valid as the original. My consent and authorization shall remain valid for the duration of my claim unless I revoke these in writing.

Plan Member Signature _____ Date _____
MMM/DD/YYYY

6. PROVINCIAL GOVERNMENT HEALTH INSURANCE (GHIP) AUTHORIZATION AND RELEASE

I agree that, pursuant to the terms of this policy and in respect of the applicable provincial health insurance legislation pertaining to freedom of information and protection of privacy; and in consideration for any monies Co-operators Life Insurance Company may advance to me as a result of the issuance of this policy, hereby irrevocably:

1. direct and authorize GHIP to make payment in respect of my claim for out-of-country health services to Co-operators Life Insurance Company directly and I hereby release GHIP, upon payment to Co-operators Life Insurance Company, from any further claim or cause of action in connection therewith;
2. consent and authorize GHIP to directly collect information contained in the claim and source documents pursuant to the applicable freedom of information and protection of privacy legislation and the applicable provincial health insurance legislation; and
3. consent to the disclosure by GHIP to Co-operators Life Insurance Company of such personal information as may be necessarily required for the processing of my claim for out-of-country health services, including the details of any duplicate payment made directly to me or on my behalf.

Plan Member Signature _____ Date _____
MMM/DD/YYYY

7. PRIVACY AND DECLARATION

CO-OPERATORS LIFE INSURANCE COMPANY PRIVACY STATEMENT

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.

8. DECLARATION

I have read and understood the privacy statement and I consent to the collection, use, retention and disclosure of my personal information or those of my dependents for the purposes stated above. I understand that I may revoke my consent at any time in writing and acknowledge that should I do so, my claim may not be adjudicated.

I hereby assign to Co-operators Life Insurance Company any benefits obtainable from other sources for losses covered under this policy. I authorize and direct these sources to release payments to Co-operators Life Insurance Company and for Co-operators Life Insurance Company to release pertinent payments to other parties for the purposes of processing my claim.

I certify that the information contained herein is true, complete and accurate and that each of the listed expenses was purchased and/or incurred in connection with the medical treatment of the above-named individuals. I acknowledge that the submission of false or incomplete information may result in the delay or denial of this claim. In the event there is suspicion and/or evidence of fraud and/or plan abuse concerning this claim, I acknowledge and agree that Co-operators Life Insurance Company may investigate and that information about me, my spouse and/or dependents pertaining to this claim may be used and disclosed to any relevant organization including regulatory bodies, government organizations, medical suppliers, and other insurers, and where applicable my plan sponsor, for the purpose of investigation and prevention of fraud and/or plan abuse.

If Co-operators Life Insurance Company pays me an amount that exceeds the benefit(s) to which I am entitled under the policy (the “overpayment amount”), then I acknowledge and agree that: (a) I am indebted to Co-operators Life Insurance Company for such overpayment; (b) The Co operators has the right to recover the overpayment amount through any means available by law; and (c) Co-operators Life Insurance Company will offset any benefits payable to me by the overpayment amount until Co-operators Life Insurance Company has recovered the overpayment amount in full.

I declare my statements above, including all other past and future statements made through personal or telephone interviews relating to my claim, to be true, complete, current and accurate.

Plan Member Signature _____ Date _____
MMM/DD/YYYY