the co-operators®
A Better Place For You®

GROUP BENEFITS
EXTENDED HEALTH CARE CLAIM FORM

INSTRUCTIONS

Use this form for all medical expenses and services. Please print clearly and be sure all sections are complete to avoid delays in processing your claim. Attach the original receipts for each expense claimed and retain a copy for your records.

Mail your completed form to:

Co-operators Life Insurance Company
Extended Health Care Claims
1900 Albert Street
Regina, SK S4P 4K8

HEALTH CARE SPENDING ACCOUNT (HCSA)

☐ Reimburse any unpaid portion of this claim from my HCSA

These expenses must meet CRA's rules and guidelines and it is your responsibility to determine if your medical expenses are allowed.

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 _____ _____ _____ Date of Birth _____
First Name Initial Last Name MMM/DD/YYYY

Address _____ _____ _____ _____ Daytime Phone # (_____)_____
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 Health_Support_Representatives@cooperators.ca

2. CLAIM INFORMATION

List the name of persons for whom you are claiming expenses. **Attach original receipts and ensure each receipt clearly indicates the type of expense being claimed.**

Name of Person Incurring Expense	Date of Birth MMM/DD/YYYY	Relationship to Plan Member	Full-time Student	Disabled Dependent	Amount Claimed
			■ Yes ☐ No	☐ Yes ☐ No	
			☐ Yes ☐ No	☐ Yes ☐ No	
			☐ Yes ☐ No	☐ Yes ☐ No	
			☐ Yes ☐ No	☐ Yes ☐ No	
				Total Amount Claimed	$

Are the claimed expenses eligible under your Provincial Health Plan? ■ Yes ☐ No

If yes, please attach a copy of the payment or denial.

Is treatment required as the result of an accident? ■ Yes ☐ No

If yes, what kind of accident? ☐ Motor Vehicle ☐ Other _____

Is a claim being made for Worker's Compensation Benefits? ☐ Yes ■ No

EXPENSE DETAILS

Prescription Drug Expenses
Official pharmacy or clinic/physician receipts are required

All receipts must include:

- Patient name
- Date of service
- Rx number
- Drug name
- Quantity dispensed
- Drug identification number (DIN)

Paramedical Expenses
Chiropractor, massage therapist, physiotherapist, etc.

All receipts must include:

- Patient name
- Date of service
- Name of treatment provided
- Charge for each service
- Provider's name, address, telephone number and professional designation
- Amount paid by the provincial plan, if applicable

Medical Expenses
Medical equipment, appliances and services

All receipts must include:

- Patient name
- Date item was received
- Name of item purchased or a detailed description of the services or supplies
- Charge for each item/service
- Provider's name, address, telephone number and professional designation
- Amount paid by the provincial plan, if applicable

Vision Care Expenses
Laser eye surgery, glasses, contact lenses and eye exams

All receipts must include:

- Patient name
- A breakdown of charges for lenses and frames or eye exam
- Date eyewear was dispensed
- Date the eye exam was performed and paid for

3. CO-ORDINATION OF BENEFITS

Claims for dependent children must be submitted first under the plan of the parent whose birthday comes first in the calendar year. If this expense has been considered by another carrier, you **must** attach the original explanation of benefits from that plan along with **copies** of the receipts.

Are you or your dependents covered by another plan? ■ Yes ☐ No If yes, provide the following:

Spouse Date of Birth _____ (Day) _____ (Month) Insurance Company Name/Source _____ Policy _____

If your spouse's benefit plan is with Co-operators Life Insurance Company, do you want us to process the claim through both benefit plans? ☐ Yes ☐ No

Spouse's Policy _____ Certificate _____

4. PLAN SPONSOR AUTHORIZATION (ONLY IF REQUIRED)

Employment Date _____ (MMM/DD/YYYY) Employee's/Member's Effective Date _____ (MMM/DD/YYYY) Dependent's Effective Date _____ (MMM/DD/YYYY)

Termination Date (if applicable) _____ (MMM/DD/YYYY) Retirement Date _____ (MMM/DD/YYYY) Status ■ Single ☐ Couple ☐ Family

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

5. AUTHORIZATION

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 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. I authorize any physician, dentist or any health care provider and/or facility, any insurance company, benefit service provider and any other person or organization having any medical or other relevant personal information regarding me or my spouse and/or dependant to release to and exchange with Co-operators Life Insurance Company, the group plan administrator or their representatives and/or agents any and all information necessary to investigate and confirm the accuracy and validity of this claim, determine eligibility for benefits and/or administer the claim and group benefits plan. I confirm that I am authorized to act on behalf of my spouse and/or dependants for such purposes. Any copy of this authorization shall be as valid as the original.

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 my plan (the Overpayment Amount), then I acknowledge and agree that: (a) I am indebted to Co-operators Life Insurance Company for the Overpayment amount (b) Co-operators Life Insurance Company 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.

Plan Member Signature _____ Date _____ (MMM/DD/YYYY)

6. PRIVACY

Co-operators Life Insurance Company Privacy Statement

At The Co-operators, we recognize and respect the importance of privacy. When you apply for insurance or open an account with us, we will ask for your consent to collect, use, keep and share your personal information. We will explain what information we need, what we will use it for and who we will share it with. We will open a confidential file to collect, use, keep and share your personal information for the purposes of confirming your identity, reviewing your insurance needs and determining suitability of our products and services for you, assessing your application for insurance, issuing and administering your policy, including assessing and processing claims, administering your investments, meeting our contractual and regulatory obligations, detecting and preventing fraud, and performing business and statistical analysis. We will not share your personal information for other purposes, except with your consent or as required or permitted by law.

We may tell you about products and services that may be of interest to you. You can tell us what information you want to receive from us and you can withdraw your consent at any time. 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 people we have authorized who need to use it to perform their duties. This may include our third-party service providers who may use your personal information for processing, storage, analysis and disaster recovery purposes outside of Canada. They could be required by law to give your personal information to courts, governments or regulators outside of Canada. To protect your personal information, we ensure that privacy and security requirements are included in all third-party service provider contracts.

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 how we collect, use, keep and share your personal information, please contact our Privacy Officer at The Co-operators at 1-888-887-7773, or by e-mail: privacy@cooperators.ca