

# GROUP BENEFITS LIFE WAIVER OF PREMIUM PLAN MEMBER STATEMENT

## MAILING ADDRESS

Mail: Co-operators Life Insurance Company  
Group Life Claims Department  
1920 College Avenue  
Regina SK S4P 1C4  
  
Fax: 1-866-889-9925

## INSTRUCTIONS

Please print clearly and be sure all sections are complete to avoid delays in processing the claim.

## 1. PLAN MEMBER INFORMATION

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

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

Plan Sponsor/Employer \_\_\_\_\_ Phone Number ( \_\_\_\_\_ ) \_\_\_\_\_

Date of Birth\* MMM/DD/YYYY  Male  Female Height \_\_\_\_\_ Weight \_\_\_\_\_

\* If age 60 or over, enclose a copy of your birth certificate

Social Insurance Number\*\* \_\_\_\_\_

\*\* Social Insurance Number is for taxable plans and any Contribution To Pension benefits.

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

Phone Number ( \_\_\_\_\_ ) \_\_\_\_\_ Cell Number ( \_\_\_\_\_ ) \_\_\_\_\_

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.

## 2. CLAIM INFORMATION

Describe your present medical condition, its cause and history \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Date Symptoms Began MMM/DD/YYYY Date of first treatment for this illness/injury MMM/DD/YYYY

Medical condition has prevented me from working since MMM/DD/YYYY

Have you ever had a similar injury or illness in the past? .....  Yes  No

If yes, please describe your condition, the date of its onset, any treatment you received for it, and any time lost from work because of it.

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

List all physicians you have seen for your present medical condition (ensure copies of all available specialists' reports are provided):

Physician	Address	Dates Seen		Next Appointment Date
		From	To	
		<small>MMM/DD/YYYY</small>	<small>MMM/DD/YYYY</small>	<small>MMM/DD/YYYY</small>
		<small>MMM/DD/YYYY</small>	<small>MMM/DD/YYYY</small>	<small>MMM/DD/YYYY</small>
		<small>MMM/DD/YYYY</small>	<small>MMM/DD/YYYY</small>	<small>MMM/DD/YYYY</small>

List any dates of hospitalization From MMM/DD/YYYY To MMM/DD/YYYY

**2. CLAIM INFORMATION (CONTINUED)**

Has your physician told you to restrict your activities in any way? .....  Yes  No

If yes, describe what he/she told you about restricting your activities \_\_\_\_\_  
\_\_\_\_\_

How do these restrictions interfere with your ability to perform your job duties? \_\_\_\_\_  
\_\_\_\_\_

Have you discussed a return to work with your employer? .....  Yes  No

Own Occupation       Modified Occupation       Part-Time       Full-Time  
Date \_\_\_\_\_ Date \_\_\_\_\_ Date \_\_\_\_\_ Date \_\_\_\_\_  
MMM/DD/YYYY      MMM/DD/YYYY      MMM/DD/YYYY      MMM/DD/YYYY

Have you discussed a return to work with your physician? .....  Yes  No

Own Occupation       Modified Occupation       Part-Time       Full-Time  
Date \_\_\_\_\_ Date \_\_\_\_\_ Date \_\_\_\_\_ Date \_\_\_\_\_  
MMM/DD/YYYY      MMM/DD/YYYY      MMM/DD/YYYY      MMM/DD/YYYY

**3. OCCUPATION AND EDUCATION INFORMATION**

**EDUCATION TRAINING**

Indicate the highest grade level of education completed  Grade 6 or under  7  8  9  10  11  12  13

Type of degree, diploma, or certificate \_\_\_\_\_

Other training, special or vocational courses \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**WORK EXPERIENCE**

**Present Employment**

Occupation \_\_\_\_\_ Date Started \_\_\_\_\_  
MMM/DD/YYYY

Duties \_\_\_\_\_

**Previous Employment**

Please complete the following, providing details of your previous positions

1. Employer \_\_\_\_\_ Job Title \_\_\_\_\_ Dates of Employment \_\_\_\_\_  
Duties \_\_\_\_\_

2. Employer \_\_\_\_\_ Job Title \_\_\_\_\_ Dates of Employment \_\_\_\_\_  
Duties \_\_\_\_\_

3. Employer \_\_\_\_\_ Job Title \_\_\_\_\_ Dates of Employment \_\_\_\_\_  
Duties \_\_\_\_\_

**Job Skills**

What skills have you acquired in your current and previous jobs? (e.g. typing, operation of equipment, supervisory skills, etc) Where appropriate, give level of proficiency.

\_\_\_\_\_  
\_\_\_\_\_

**Community Interests**

Outline your past or present involvement with any community or volunteer organizations.

\_\_\_\_\_  
\_\_\_\_\_

**Hobbies**

\_\_\_\_\_  
\_\_\_\_\_

**4. PRIVACY**

**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.

Co-operators Life Insurance Company will collect, use and disclose personal information about you, your spouse or dependents for the purposes of providing group benefit plan administration, underwriting and claim services. Only authorized personnel have access to your information, and 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. Your personal information may be collected by or transferred to a service provider outside of Canada for processing, storage, analysis or disaster recovery. You can find more details about Co-operators Life Insurance Company's privacy policy at [www.cooperators.ca](http://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: The Co-operators Privacy Officer: Priory Square, Guelph ON N1H 6P8 Tel: 1-888-887-7773 email: [privacy@cooperators.ca](mailto:privacy@cooperators.ca) (please indicate Co-operators Life Insurance Company in your inquiry).

**5. PLAN MEMBER AUTHORIZATION**

I have read and understood the section entitled "Privacy" and I consent to the collection, use and disclosure of my personal information for the purposes stated. I hereby authorize any physician, hospital, clinic, pharmacy or any other medical or health care provider or facility, the group plan administrator 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, employment, vocational, financial or other relevant personal information or records regarding me to release to and exchange with Co-operators Life Insurance Company, 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, determine my eligibility for benefits, administer my claim, assess and facilitate my ability to return to work and administer the group benefits plan and coverage.

In consideration for any payment of benefits made to me by Co-operators Life Insurance Company, the policyholder, or plan administrator (the "payor"), I hereby agree to refund, in accordance with the provisions of the policy/plan document, from any source as defined under All Source Benefit and/or Other Income, any monies that may be due to the payor and further irrevocably assign all right, title, and interest of such monies and any group insurance proceeds to the payor for such purpose.

I hereby authorize Co-operators Life Insurance Company to deposit disability payments directly to my account and to exchange my relevant financial information with my financial institution for such purpose. This authorization shall remain valid for the duration of my claim unless revoked by me in writing.

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 Plan Member 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.

**For Quebec residents** - Under this assignment, the definition of All Source Benefits and/or Other Income does not include the benefits paid by the Commission de la santé et sécurité du travail or by the Commission des lésions professionnelles.

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