

GROUP BENEFITS LIFE WAIVER OF PREMIUM PLAN SPONSOR 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.
For clients not billed by The Co-operators, please attach a copy of the plan member's enrolment form, a copy of the billing, and a copy of the LTD approval letter.

1. PLAN MEMBER INFORMATION

Plan Member _____
First Name Initial Last Name

Group _____ Account _____ Certificate _____

Date of Birth _____ Male Female Social Insurance Number* _____
MMM/DD/YYYY

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

Address _____
Street City Province Postal Code

Phone Number (_____) _____ Cell Number (_____) _____

2. COVERAGE INFORMATION

Class or union affiliation to which the plan member belongs (if applicable) _____

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
 If "No" please provide details. _____

The plan member is Hourly Salaried Commissioned***
*** For commissioned or self employed plan members provide T4, notice of assessment, and statement of expenses for the previous two years.

The plan member is Full-time Part-time Contract (please enclose a copy of the contract agreement)

Average hours worked in a normal work week _____ What days of the week does the plan member work? _____
(excluding overtime) (ie. Monday to Friday)

Is the plan member involved in shift work? Yes No If yes, what is the rotation schedule? _____

Date employment terminated (if applicable) _____ Reason _____
MMM/DD/YYYY

3. EARNINGS/BENEFIT INFORMATION (ATTACH COPY OF PAY STUB FOR LAST FULL PAY PERIOD)

Plan Member Gross Salary \$ _____ Hourly Weekly Bi-weekly Semi-monthly Monthly Annually
(exclude overtime, commissions, bonuses)

Effective Date of Salary _____ Is any portion of the premium paid by the plan sponsor/employer? No (non-taxable) Yes (taxable)
MMM/DD/YYYY

4. OCCUPATIONAL INFORMATION

What was the regular occupation of the plan member immediately prior to his/her no longer attending work? _____

How long has the plan member worked in this position? _____

Please describe this plan member's regular occupation as well as any modifications, if any. **Attach a copy of the job description provided by the company.**

When did the plan member's illness or injury first appear to affect his/her work? _____
MMM/DD/YYYY

4. OCCUPATIONAL INFORMATION (CONTINUED)

From your observations how did the plan member's performance change? _____

Have you discussed a return to work with the plan member? Yes No If yes, provide date and details _____
MMM/DD/YYYY

Has this job been eliminated? Yes No

PHYSICAL DEMANDS ANALYSIS

The following physical demands analysis of the plan member's occupation is to be completed by his/her supervisor.
 In the appropriate column, please specify the average amount of time (in hours) the following activities are regularly performed:

| | | Continuously | Daily Total |
|--|-----------------------------|--------------|-------------|
| 1 | Sitting | | |
| 2 | Standing | | |
| 3 | Driving | | |
| 4 | Bending | | |
| 5 | Climbing up and down stairs | | |
| 6 | Lifting | | |
| <input type="checkbox"/> 0-10 lbs <input type="checkbox"/> 10-20 lbs <input type="checkbox"/> 20-50 lbs <input type="checkbox"/> 50+ lbs with lifting device? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 7 | Pushing/Pulling | | |
| <input type="checkbox"/> 0-10 lbs <input type="checkbox"/> 10-20 lbs <input type="checkbox"/> 20-50 lbs <input type="checkbox"/> 50+ lbs | | | |

Please describe work environment (i.e. temperature, noise levels, chemical/dust exposure, etc.) _____

Please list any machines, tools, or other equipment that the plan member uses in the occupation _____

Please provide any additional information that may be relevant to this claim which has not been previously provided _____

5. DECLARATION

Name of Plan Sponsor _____

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

Name of Supervisor _____ Phone 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.

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

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.