

GROUP BENEFITS LONG TERM DISABILITY PLAN SPONSOR STATEMENT

MAILING ADDRESS	INSTRUCTIONS
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Mail: Co-operators Life Insurance Company Disability Claims Department 1920 College Avenue Regina SK S4P 1C4 Fax: 1-866-889-9926	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 and a copy of the billing. If illness/injury is claimed to be work related, the plan member must make an application to Workers' Compensation in addition to this plan.
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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 plan member became insured under The Co-operators LTD 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
 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

Current tax exception per Federal TD1 \$ _____ (Attach TD1) (In Quebec, tax deductions are according to the latest TP-1015:3)

State regular payroll deductions for: Pension (if applicable) \$ _____ RRSP (if applicable) \$ _____

OTHER INCOME:

<input type="checkbox"/> Sick Pay From _____ To _____ <small style="margin-left: 100px;">MMM/DD/YYYY</small> <small style="margin-left: 100px;">MMM/DD/YYYY</small>	<input type="checkbox"/> Vacation Pay From _____ To _____ <small style="margin-left: 100px;">MMM/DD/YYYY</small> <small style="margin-left: 100px;">MMM/DD/YYYY</small>
<input type="checkbox"/> Workers Compensation From _____ To _____ <small style="margin-left: 100px;">MMM/DD/YYYY</small> <small style="margin-left: 100px;">MMM/DD/YYYY</small> Status _____	<input type="checkbox"/> Employment Insurance From _____ To _____ <small style="margin-left: 100px;">MMM/DD/YYYY</small> <small style="margin-left: 100px;">MMM/DD/YYYY</small> Status _____
<input type="checkbox"/> Short Term Disability From _____ To _____ <small style="margin-left: 100px;">MMM/DD/YYYY</small> <small style="margin-left: 100px;">MMM/DD/YYYY</small> Status _____	<input type="checkbox"/> Other From _____ To _____ <small style="margin-left: 100px;">MMM/DD/YYYY</small> <small style="margin-left: 100px;">MMM/DD/YYYY</small> Please explain _____

Plan Member _____
First Name Initial Last Name

4. PENSION INFORMATION (IF APPLICABLE)

At the date of disability, was the plan member enrolled in one of the following plans? Yes No

Defined Benefit Pension Plan Defined Contribution Pension Plan Group RRSP Individual RRSP

Administered by (financial institution or organization) _____

Address _____
Street City Province Postal Code

Date plan member became or will become eligible to contribute _____
MMM/DD/YYYY

Plan Name _____ Registration/Account Number _____

Contribution levels at date of disability Employee _____% Employer _____%

5. 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

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

Are you able to accommodate modified: Hours Yes No Duties Yes No

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 _____

Plan Member _____
First Name Initial Last Name

6. DECLARATION

Name of Plan Sponsor _____

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

Name of Supervisor _____ Phone Number (_____) _____

Address _____
Street City Province Postal Code

Form completed by _____ Title _____
Name (please print)

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

If you would like The Co-operators to communicate with you by email about this disability claim, please provide your email _____

We use reasonable safeguards to protect all information collected, used, retained and disclosed in the course of conducting business; however, email may be vulnerable to interception by unauthorized parties. We discourage you from emailing personal or sensitive information. If you provided your email to us, or if you contacted us by email, we accept this as your consent to communicate with you by email. If you do not wish for us to communicate with you by email, please notify us at your earliest convenience.

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.