the co-operators®
A Better Place For You®

GROUP BENEFITS NOTICE OF DEATH CLAIMANT STATEMENT

This guide is designed to assist you in the claim submission process.

the co-operators
A Better Place For You®

GROUP BENEFITS NOTICE OF DEATH CLAIMANT STATEMENT

LIFE BENEFITS

Life benefits are intended to provide financial support for plan members and their families in the event of a death.

THE FOLLOWING INFORMATION IS REQUIRED

Notice of Death - Plan Sponsor Statement

Ensure the Plan Sponsor Statement is submitted to our office by your employer.

Notice of Death - Claimant Statement

When proceeds are payable to a named beneficiary:

The Claimant Statement should be completed by the beneficiary, except in the following situations:

- If any named beneficiary has predeceased the life insured, proof of death must be provided in the form of a death certificate.
- If a trustee was appointed by the deceased to act on behalf of the beneficiary, the trustee should complete the Claimant Statement.
- If the beneficiary is a minor and the deceased had not appointed a trustee, contact The Co-operators to determine who should complete the Claimant Statement. Legislation regarding payment to minors varies from province to province.
- If the beneficiary is not able to handle their own financial affairs, the Claimants Statement should be completed by their legal representative by virtue of a Power of Attorney Document or Court-Appointed Committee. Please submit a copy of your legal appointment with the other claim documents.

  In Quebec:

  - The beneficiary's tutor should complete the Claimant Statement.

  Note: In Quebec, the surviving spouse is automatically appointed as the minor's tutor, unless prohibited by a court order

When proceeds are payable to the insured's estate:

The Claimant Statement should be completed by the estate's legal representative. Please contact us for information as additional information may be required which could include the following:

- A notarized copy of the will and probate, or
- Certificate of Appointment of Estate Trustee with or without a will (Ontario), or
- Letter of Administration

  In Quebec:

  - A notarial will – a notarized copy
  - Holographic Will/Made before Witnesses - a certified copy of a judgement and the will signed by the court clerk or the assistant court clerk which declares duly probated the deceased's will; or a notarized copy of the will as well as the minutes of probate
  - No will - a declaration of legal heirs. In this case, each of the heirs should complete a separate Claimant Statement for their share of the insurance proceeds

Proof of Death

For claims $150,000 and under, we will accept an original death certificate and/or a funeral director's statement of death. For claims greater than $150,000, the Physician Statement is required. Depending on the circumstances surrounding the death, The Co-operators may require additional information including, but not limited to the following:

- Coroner's report
- Police investigation reports
- Additional medical information

AUTHORIZATION AND PRIVACY

We need your permission to obtain information that will help us assess your claim. By signing the authorization request, you give Co-operators Life Insurance Company permission to obtain this information from the insured's treatment providers, plan sponsor, other insurers and hospitals where he/she received treatment. Co-operators Life Insurance Company is committed to protecting the privacy, confidentiality, accuracy and security of the personal information it collects, uses, retains and discloses in the course of conducting business. Co-operators Life Insurance Company will abide by all federal and provincial privacy legislation which governs the protection of all personal information in it custody. For further information regarding Co-operators Life Insurance Company privacy policies, please refer to the booklet or our website at www.cooperators.ca/en/PublicPages/Privacy.aspx

CONTACT INFORMATION

If you have any questions or if you need help with your life claim, please contact your plan administrator or our office at 1-866-442-3098. Please have your group policy and certificate number available.

the co-operators®
A Better Place For You®

GROUP BENEFITS NOTICE OF DEATH CLAIMANT 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.

The completed form can be faxed to the number provided or the original can be mailed to the address provided.

1. PLAN MEMBER INFORMATION

Plan Member _____ (First Name) _____ (Initial) _____ (Last Name)

Group _____ Account _____ Certificate _____

Plan Sponsor/Employer _____ Phone (_____) _____

2. DECEASED INFORMATION

Name _____ (First Name) _____ (Initial) _____ (Last Name)

Date of Birth _____ (MMM/DD/YYYY) Place of Birth _____ Province of Legal Residence _____

Date of Death _____ (MMM/DD/YYYY) Place of Death _____

Cause of Death (provide details) _____

Duration of illness, if applicable _____ Names and addresses of attending physician(s) _____

_____

Was death accidental? ☐ Yes ☐ No Location and type of accident _____

Date of Accident _____ (MMM/DD/YYYY) Time _____ ☐ a.m. ☐ p.m.

Name and address of investigating police department, if applicable _____

_____

3. CLAIMANT INFORMATION

Claimant _____ (First Name) _____ (Initial) _____ (Last Name)

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

Phone (_____) _____ Date of Birth _____ (MMM/DD/YYYY) *Social Insurance Number _____

* Social Insurance Number is required in the event interest is deemed taxable

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.

In what capacity do you claim the insurance money?

☐ Beneficiary ☐ Executor/Executrix/Liquidator of the Succession ☐ Trustee

☐ Power of Attorney ☐ Signing Officer ☐ Other _____

4. AUTHORIZATION

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.

I hereby authorize any physician, hospital, clinic or any other medical or health care provider or facility, the group plan administrator and/or adjudicator or their agent, any insurance company, reinsurer, provincial health insurance plan, government department or agency and any other person, organization or institution having any medical or other relevant personal information or records regarding the deceased to release to and exchange with The Co-operators, 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 this claim and to administer this claim. I understand that my refusal or withdrawal of consent may delay claims adjudication or result in the denial of this claim. I declare that the information provided in this 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.

Name of Deceased _____ Relation to Deceased _____

Signature of Claimant _____ Date _____
MMM/DD/YYYY