the co-operators
A Better Place For You®

GROUP BENEFITS NOTICE OF DEATH 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 and a copy of the billing.

If the sum insured is based on salary, please attach a copy of the plan member's pay stub for the last full pay period.

1. PLAN MEMBER INFORMATION

Plan Member ______________________ (First Name) ____ (Initial) ______________________ (Last Name)

Group ______________ Account ______________ Certificate ______________

Date of Birth* ____________ (MMM/DD/YYYY) ☐ Male ☐ Female Date of Employment ____________ (MMM/DD/YYYY) Date Last Worked ____________ (MMM/DD/YYYY)

* If age is over 60, please attach a copy of the plan member's birth certificate

If plan member has been absent from work for more than 1 week, please provide reason ______________

Plan Member occupation as of date last worked ______________

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

The plan member is ☐ Hourly ☐ Salaried ☐ Commissioned The plan member is ☐ Full-time ☐ Part-time

2. CLAIM INFORMATION

Death of: ☐ Plan Member ☐ Dependent Relationship to Plan Member ______________

Name of Deceased ______________________ (First Name) ____ (Initial) ______________________ (Last Name)

Date of Death ____________ (MMM/DD/YYYY)

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

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

Effective Date of Salary ____________ (MMM/DD/YYYY)

4. DECLARATION

Name of Plan Sponsor ______________________

Phone Number (____) ____________ Cell Number (____) ____________ Fax 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 ______________________ (Name (please print)) Title ______________

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.