the co-operators®
A Better Place For You®

GROUP BENEFITS
SHORT TERM DISABILITY
PLAN SPONSOR STATEMENT

MAILING ADDRESS

Mail: Co-operators Life Insurance Company
Disability Claims Department
1920 College Avenue
Regina SK S4P 1C4

Fax: 1-866-889-9926

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 illness/injury is claimed to be work related, the plan member must make an application to Workers' Compensation in addition to this plan.

1. PLAN MEMBER INFORMATION

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

Group _____ Account _____ Certificate _____

Date of Birth _____ (MMM/DD/YYYY) ☐ Male ☐ Female 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 (_____)_____

2. COVERAGE INFORMATION

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

Date plan member became insured under The Co-operators STD policy _____ (MMM/DD/YYYY) **and** with a previous carrier's policy _____ (MMM/DD/YYYY)

Date of Employment _____ (MMM/DD/YYYY) Date Last Worked _____ (MMM/DD/YYYY) Date Returned to Work _____ (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*** The plan member is ☐ Full-time ☐ Part-time

*** For commissoned or self employed plan members provide T4, notice of assessment, and statement of expenses for the previous two years.

Average hours worked in a normal work week _____ (excluding overtime) What days of the week does the plan member work? _____ (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) _____ (MMM/DD/YYYY) Reason _____

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) Is any portion of the premium paid by the plan sponsor/employer? ☐ No (non-taxable) ☐ Yes (taxable)

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

OTHER INCOME:

☐ Sick Pay	From _____ (MMM/DD/YYYY)	To _____ (MMM/DD/YYYY)	☐ Vacation Pay	From _____ (MMM/DD/YYYY)	To _____ (MMM/DD/YYYY)
☐ Workers Compensation	From _____ (MMM/DD/YYYY) Status _____	To _____ (MMM/DD/YYYY)	☐ Employment Insurance	From _____ (MMM/DD/YYYY) Status _____	To _____ (MMM/DD/YYYY)
☐ Other	Please explain _____			From _____ (MMM/DD/YYYY)	To _____ (MMM/DD/YYYY)

Plan Member _____ _____ _____
First Name Initial Last Name

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.**

_____

_____

5. 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)

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.

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.