the co-operators®
A Better Place For You®

OPTIONAL GROUP CRITICAL ILLNESS INSURANCE APPLICATION

Optional Critical Illness insurance provides you and your spouse the opportunity to purchase additional Critical Illness insurance to supplement existing Critical Illness insurance protection.

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GENERAL INFORMATION

This brochure is designed to outline the benefits for which you are eligible and does not create or confer any contractual or other rights. All rights with respect to the benefits of an insured person will be governed solely by the group policy issued by Co-operators Life Insurance Company.

WHY DO I NEED ADDITIONAL COVERAGE?

Statistics indicate that Canadian families require insurance coverage at a level of four to six times the annual household income. One of the most valuable assets that we as individuals possess, is the ability to earn an income. Loss of income as a result of medical illness can have a devastating effect on a family's lifestyle and dreams unless provisions are made for the replacement of lost income.

IS A MEDICAL EXAM REQUIRED?

Co-operators Life Insurance Company reserves the right to request a medical examination or other evidence at no expense to you. You will be notified directly if one is required.

WHEN DOES INSURANCE TAKE EFFECT?

Your coverage will take effect once you receive written confirmation from Co-operators Life Insurance Company.

HOW ARE PREMIUMS PAID?

Payment of premium is made by payroll deduction.

HOW DOES IT WORK?

Coverage is available in units as outlined in the rate sheet supplied to your plan sponsor. You can choose the amount of protection that is right for you.

> As an example, a 34 year old person wishes to purchase 10 units =($50,000) of additional Critical Illness coverage. If the cost of this amount of coverage under this benefit amount was $1.00 per unit per month, then: $1.00 x 10 units = $10.00 per month.

HOW DO I APPLY?

To apply, complete the attached application form and forward to:

Co-operators Life Insurance Company
Attn: Group Medical Underwriting Department
1920 College Avenue
Regina, SK S4P 1C4

Fax to: (306) 347-6180 or toll-free: 1-866-889-9924

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To avoid delays, please complete the required information by printing clearly in ink.
This form must be received in our office within 60 days of the application being signed, otherwise a new application must be completed.

PLAN MEMBER INFORMATION

Group _____ Account _____ Certificate _____ Group Name _____

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

Is plan member actively at work? ☐ Yes ☐ No If no, why? _____

APPLICANT INFORMATION

Applicant: ☐ Plan Member ☐ Spouse _____ (First Name) _____ (Initial) _____ (Last Name)

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

Phone Number: Home (_____) _____ Work (_____) _____ Cell (_____) _____

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

Annual Salary $ _____ Occupation _____

COVERAGE AMOUNT

Existing Optional Critical Illness Amount: $ _____ (under this group)

New Total Amount Requested: $ _____

APPLICANT DECLARATION OF INSURABILITY

1. Have any of your parents or siblings been diagnosed before their 60th birthday with cancer, tumour, leukemia, lymphoma, Hodgkin's disease, heart disease, heart attack, coronary artery disease, stroke, high blood pressure, diabetes, polycystic kidney disease, kidney disorder, liver disorder, multiple sclerosis, Alzheimer's disease, dementia, Huntington's disease, Parkinson's disease, multiple sclerosis, or Amyotrophic Lateral sclerosis (ALS /Lou Gehrig's disease)? ☐ Yes ☐ No

   If yes, specify condition, relationship, and age at diagnosis _____

2. Have any of your parents, brothers or sisters had any hereditary disorders? ☐ Yes ☐ No

   If yes, specify (e.g. Huntington's chorea, polycystic kidney disease, etc.) _____

3. Have you had any symptoms of, or treatment for, any medical condition, disorder or ailment that resulted in your hospitalization within the last year? ☐ Yes ☐ No

   If yes, give details below:

Name of Disorder	Date of Onset & Duration MMM/DD/YYYY	Symptoms	Attending Physician or Hospital	Treatment & Results

4. Height _____ ☐ ft/in ☐ cm Weight _____ ☐ lbs ☐ kg

   Has your weight changed in the past year? ☐ Yes ☐ No

   If so, how much? _____ Why? _____

5. Who is your regular physician or family doctor? _____

   If none, walk-in clinic visited: _____ (Street) _____ (City) _____ (Province) _____ (Postal Code)

   Approximate Date Last Seen _____ (MMM/DD/YYYY) Reason and Result _____

APPLICANT DECLARATION OF INSURABILITY (CONTINUED)

6. Have you ever had or been told you had any of the following:

   a. Chronic obstructive pulmonary disorder (COPD), emphysema, sleep apnea, tuberculosis, asthma, chronic bronchitis, or any other lung disease or disorder? ☐ Yes ☐ No

   b. Stroke, transient ischemic attack (TIA), heart attack, heart surgery, heart murmur, coronary artery bypass or angioplasty, irregular heartbeat, a pacemaker, chest pain, or shortness of breath? ☐ Yes ☐ No

   c. Gastrointestinal disorder such as ulcer, rectal bleeding, Crohn's disease, ulcerative colitis, diverticulitis, or any disorder of the intestines, the esophagus, the stomach or the pancreas? ☐ Yes ☐ No

   d. Diabetes, endocrine disorder, kidney or bladder disease? ☐ Yes ☐ No

   e. Cancer, tumour, polyp, cyst, dysplastic nevi, skin growth, mole removal, leukemia, lymphoma, melanoma, nodule, growth, abnormal pap smear or mammogram, abnormal PSA test, or any blood disorder? ☐ Yes ☐ No

   f. Head injury, epilepsy, cognitive impairment, memory loss, muscle weakness, numbness, tingling, dizziness, paralysis, multiple sclerosis, amyotrophic lateral sclerosis (ALS), Huntington's disease, Parkinson's disease, motor neuron disease, dementia, Alzheimer's disease, or brain disorder? ☐ Yes ☐ No

   g. Neuritis, arthritis, rheumatism, back, spine, bone, joint, or muscle disorder? ☐ Yes ☐ No

   h. Nervous or mental disorders, including depression, anxiety or suicidal thoughts? ☐ Yes ☐ No

   i. Tested positive for HIV? ☐ Yes ☐ No

   j. Disorder of eyes or ears, such as blindness, optical neuritis, tinnitus, or deafness? ☐ Yes ☐ No

   k. Liver disease, or hepatitis, including hepatitis carrier state? ☐ Yes ☐ No

   l. Any disease, impairment or deformity not named above? ☐ Yes ☐ No

   If yes to any question in number 6, give details below:

Name of Disorder	Date of Onset & Duration MMM/DD/YYYY	Symptoms	Attending Physician or Hospital	Treatment & Results

7. Have you ever taken drugs, including marijuana and cocaine for other than medical purposes or been advised to reduce alcohol consumption or received or have been counselled to receive treatment for drug addiction or alcoholism? ☐ Yes ☐ No

   If yes, give details including: Substance _____

   Frequency of use: ☐ Daily ☐ Weekly ☐ Monthly ☐ Other _____

   Amount consumed on each occasion _____ Date last used _____ (MMM/DD/YYYY)

8. Have you ever been refused Life or Critical Illness insurance or been offered such insurance on a modified basis in any way? ☐ Yes ☐ No

   If yes, date _____ (MMM/DD/YYYY) Reason _____

9. Tobacco Use: Have you smoked or used any form of tobacco products, nicotine products or nicotine substitutes within the past twelve (12) months? ☐ Yes ☐ No

   If yes, for how long? _____ how many per day? _____

10. Within the last 5 years, have you consulted a health care professional for any symptoms, illness, condition, check-up consultation or treatment not already mentioned above? ☐ Yes ☐ No

    If yes, provide details _____

11. Within the last 5 years, have you had an electrocardiogram (ECG), x-ray, blood tests or other diagnostic tests such as a colonoscopy, mammogram, ultrasound, CT scan, magnetic resonance imaging (MRI) or echocardiogram that you have not already disclosed above? ☐ Yes ☐ No

    If yes, Include details such as name of test, date and results _____

    _____

12. Are you awaiting a consultation with a health care professional or have you been advised to have any surgical operation, any tests or investigations which have not yet been completed or for which you have not received the results? ☐ Yes ☐ No

    If yes, provide details _____

13. Within the last 6 months, have you had any condition, disease, symptoms or complaints for which you have not consulted a physician or received treatment? ☐ Yes ☐ No

    If yes, provide details _____

PRIVACY AND DECLARATION

CO-OPERATORS LIFE INSURANCE COMPANY PRIVACY STATEMENT

The Co-operators 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.

At The Co-operators, we recognize and respect the importance of privacy. When you enrol for insurance coverage or submit a claim, we establish a confidential file and collect, use and disclose your personal information for the purposes of issuing, administering, adjudicating and/or servicing your insurance. You may access and correct, if needed, the personal information in your file by sending us a request in writing.

We limit access to your personal information to our staff and other persons we have authorized who have a need to know it to perform their duties. Our systems and procedures are designed to prevent the loss, misuse, unauthorized access, disclosure, alteration, or destruction of your information. Our commitment to security extends to the contracts and agreements we sign with external suppliers and service providers. We may store or process your personal information in Canada, the United States or other countries for processing, storage, analysis or disaster recovery and, under applicable law, governments, courts, law enforcement or regulatory agencies, may, by lawful order, obtain disclosure of your personal information. You can find more details about The Co-operators privacy policy at www.cooperators.ca. If you have any questions regarding our privacy policies or about the collection, use and disclosure of your personal information, please contact our Privacy Officer at The Co operators at Priory Square, Guelph, ON, N1H 6P8, Tel: 1-888-887-7773, E-mail: privacy@cooperators.ca (please include The Co-operators company you deal with in your inquiry).

If you do not agree with our use and disclosure of your information in connection with your application and servicing any policy that we issue, we will not be able to offer you the insurance product you are interested in, service your insurance or adjudicate your claim.

APPLICANT AUTHORIZATION AND CONSENT

I have read and understood the privacy statement and I consent to the collection, use, retention and disclosure of my personal information or those of my dependants for the purposes stated above. I understand that I may revoke my consent at any time in writing and acknowledge that should I do so, my claim may not be adjudicated.

I authorize any person or organization who maintains my personal and health records or information to provide The Co-operators (or its agents, representatives, and administrators) with my personal and health information for the purpose of underwriting my application for insurance coverage, evaluating my eligibility for any insurance coverage, and adjudicating my insurance claim(s). I authorize The Co-operators to release my personal and health information to my physician, the Public Health authorities, and The Co-operators re-insurer(s), when requested. This authorization will remain valid unless I revoke it in writing. A copy of this authorization will be as effective as the original.

APPLICANT ACKNOWLEDGEMENT AND DECLARATION

I understand that The Co-operators (or its agent, representatives, and administrators) may ask me to undergo a medical or paramedical examination(s) to evaluate my eligibility for insurance coverage. If I refuse to undergo such examination(s), this may result in the delay or denial of my application for insurance coverage. I acknowledge that any information I disclose in any paramedical or medical examination or on any medical evidence form(s), questionnaire(s) or other statement(s) given as evidence of insurability will form part of my application for insurance coverage. I certify and declare that I have disclosed true, complete, and accurate information on my application for insurance coverage. I understand and acknowledge that a failure to disclose true, complete and accurate information or a misrepresentation of any material fact(s) may result in The Co-operators voiding my insurance coverage.

Signature _____ Date _____
(Spouse Signature) MMM/DD/YYYY

Signature _____ Date _____
(Plan Member Signature) MMM/DD/YYYY