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GROUP BENEFITS HEALTH EVIDENCE QUESTIONNAIRE

Reason for Medical Underwriting
(To be completed by the Plan Sponsor)

- ☐ Late Applicant
- ☐ Excess Coverage
- ☐ Salary Increase > 15%
- ☐ Evidence From 1st Dollar (0 NEM)

CONTACT INFORMATION

Mail: Co-operators Life Insurance Company
Group Benefits Administration
1900 Albert Street, Regina, SK S4P 4K8

Email: group_eligibility_administration@cooperators.ca

Phone: 1-800-667-8164 Fax: 1-866-889-9924

INSTRUCTIONS

To avoid delays, please complete all information.

The completed form can be returned by email, fax, or the original can be mailed to the address provided.

PLAN MEMBER INFORMATION

Group _____ Account _____ Certificate _____

Group Name _____

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

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

Phone Number (_____) _____ Email _____

You acknowledge that data transmitted over the internet may be intercepted and that such transmission is at your own risk. If you no longer wish to communicate with Co-operators Life Insurance Company by email, please send notification to group_medical_uw@cooperators.ca.

Date of Birth _____ (MMM/DD/YYYY) Sex: ☐ M ☐ F ☐ X Height _____ ☐ ft/in ☐ cm Weight _____ ☐ lbs ☐ kg

Occupation _____ Are you actively at work*? ☐ Yes ☐ No

If not, why? _____

*Actively at work means that you are able to perform all the usual and customary duties of your occupation on a full pay status and on a regular and continuous basis for the number of hours regularly scheduled for that day.

Has an application for insurance on your life/health ever been declined, rated or modified? ☐ Yes ☐ No

If yes, provide details _____

Do you currently have an individual life policy with Co-operators that has been issued within the last year? ☐ Yes ☐ No

If yes, provide the policy number _____

Do you have a primary physician or medical center you attend? ☐ Yes ☐ No

If yes, complete the following information. If no, provide the name of the doctor/clinic you last attended, and the reason.

Health Care Provider _____

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

Date Last Seen _____ (MMM/DD/YYYY) Reason/Outcome _____

HEALTH EVIDENCE

1. a. Have any members of your immediate biological family (father, mother, brothers, sisters) been diagnosed as having one of the following conditions under age 60: cancer, stroke, heart disease, diabetes, kidney disease, multiple sclerosis, Huntington's Disease, or any other hereditary disease? ☐ Yes ☐ No

If yes, provide details:

Condition	Relationship	Age of diagnosis

HEALTH EVIDENCE (CONTINUED)

b. Have any members of your immediate biological family (father, mother, brothers, sisters) been diagnosed as having one of the following conditions under age 70: Alzheimer's Disease, Parkinson's Disease, motor neuron disease such as ALS or Lou Gehrig's Disease? ☐ Yes ☐ No

If yes, provide details:

Condition	Relationship	Age of diagnosis

If questions 2-9, and 13 are answered "yes", please provide details in the Remarks section on the next page.
Health care providers referred to below include physicians, specialists, nurse practitioners, psychologists, social workers, counsellors and licensed naturopaths.

2. Have you ever received treatment for or seen a health care provider for any of the following?
   a. Epilepsy, seizures, multiple sclerosis, disorder of the brain or nervous system? ☐ Yes ☐ No
   b. Mental health disorders or symptoms, including depression, anxiety, bipolar disorder, post traumatic stress disorder, attention deficit hyperactivity disorder (ADHD) suicide attempts, or suicidal thoughts? ☐ Yes ☐ No
   c. High blood pressure, heart murmur, arrhythmia, palpitations, chest pain, heart attack, stroke, transient ischemic attack (TIA) or mini-stroke, aneurysm, or any other disorder of the heart or blood vessels? ☐ Yes ☐ No
   d. Hepatitis A, B, C, or type unknown? ☐ Yes ☐ No
   e. Diabetes, or sugar in the blood or urine? ☐ Yes ☐ No
   f. Leukemia, anemia, hemophilia or any disorder/ abnormality of the blood? ☐ Yes ☐ No
   g. Cancer, tumors, abnormal biopsy results, enlarged glands (nodes), skin lesions or cysts, pituitary, adrenals, or any other gland disorder? ☐ Yes ☐ No
   h. Human immunodeficiency virus (HIV) or acquired immune deficiency syndrome (AIDS)? ☐ Yes ☐ No

3. In the last 5 years, have you received treatment for or seen a health care provider for any of the following?
   a. Disorder of the eyes, ears, nose or throat? ☐ Yes ☐ No
   b. Frequent headaches, head injury, dizziness or fainting? ☐ Yes ☐ No
   c. Lungs or respiratory system, such as persistent cough, asthma, emphysema, bronchitis, tuberculosis, or sleep apnea? ☐ Yes ☐ No
   d. Disorder of the stomach, gall bladder, liver, intestines, pancreas, or digestive system? ☐ Yes ☐ No
   e. Blood in the urine, kidney stones, or any other disorder of the kidney or bladder? ☐ Yes ☐ No
   f. Arthritis, gout, sciatica, disorder of the joints or limbs, any disorder of the muscles or spine, pain in the neck or back, fibromyalgia or chronic fatigue syndrome? ☐ Yes ☐ No
   g. Thyroid or other endocrine disorder? ☐ Yes ☐ No
   h. Disorder of the prostate, breasts or reproductive organs? ☐ Yes ☐ No

4. Are you currently pregnant? ☐ Yes ☐ No

   If yes, please provide the expected delivery date _____ MMM/DD/YYYY

5. Are you currently taking medication for a condition that you have not already disclosed on this questionnaire? ☐ Yes ☐ No
6. In the past 3 years have you seen a healthcare provider for any other illness, condition, consultation or treatment that you have not disclosed on this questionnaire? ☐ Yes ☐ No
7. In the past 3 years have you missed more than fifteen days of work due to a condition, or injury? ☐ Yes ☐ No
8. Are you awaiting a consultation with a health care provider, surgical operation, or medical test or results of a medical test? ☐ Yes ☐ No
9. In the last 12 months, have you used any form of tobacco, nicotine products or substitutes (including nicotine patch or gum), e-cigarettes or vape? ☐ Yes ☐ No
10. What best describes the frequency in which you drank alcohol over the last 12 months?

Frequency	Amount
☐ Never	
☐ Daily	_____ /day
☐ Weekly	_____ /week
☐ Monthly	_____ /month
☐ Yearly	_____ /year

HEALTH EVIDENCE (CONTINUED)

11. What best describes the frequency in which you used a marijuana/cannabis product over the last 12 months?

Frequency	Amount
☐ Never	
☐ Daily	_____ /day
☐ Weekly	_____ /week
☐ Monthly	_____ /month
☐ Yearly	_____ /year

12. In the last 10 years which of the following drugs have you used?

Drug	Frequency	Date last used MMM/DD/YYYY
☐ Cocaine		
☐ Ecstacy		
☐ Sedatives		
☐ Hallucinogens		
☐ Amphetamines		
☐ Narcotics		
☐ Other		

13. In the last 10 years, have you received or been advised to obtain any treatment for alcohol or drug use (treatment includes medication, counselling, group therapy, and support groups such as Alcoholics or Narcotics Anonymous)? ..... ☐ Yes ☐ No

REMARKS

Details of "yes" answers for questions 2–9, and 13.

Question #	Date MMM/DD/YYYY	Details

PRIVACY

Co-operators Privacy Statement

At Co-operators, we recognize and respect the importance of privacy. When you apply for insurance or open an account with us, we will ask for your consent to collect, use, keep and share your personal information. We will explain what information we need, what we will use it for and who we will share it with. We will open a confidential file to collect, use, keep and share your personal information for the purposes of confirming your identity, reviewing your insurance needs and determining suitability of our products and services for you, assessing your application for insurance, issuing and administering your policy, including assessing and processing claims, administering your investments, meeting our contractual and regulatory obligations, detecting and preventing fraud, and performing business and statistical analysis. We will not share your personal information for other purposes, except with your consent or as required or permitted by law.

We may tell you about products and services that may be of interest to you. You can tell us what information you want to receive from us and you can withdraw your consent at any time. 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 people we have authorized who need to use it to perform their duties. This may include our third-party service providers who may use your personal information for processing, storage, analysis and disaster recovery purposes outside of your province of residence or Canada. They could be required by law to give your personal information to courts, governments or regulators outside of Canada. To protect your personal information, we ensure that privacy and security requirements are included in all third-party service provider contracts.

You can find more details about our privacy policy and how to contact our Privacy Officer at www.cooperators.ca/privacy.

APPLICANT DECLARATION AND AUTHORIZATION

Applicant Authorization and Consent

I authorize any person or organization who maintains my personal and health records or information to provide 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 Co-operators to release my personal and health information to my physician, the Public Health authorities, and Co-operator's 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 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 Co-operators voiding my insurance coverage.

Plan Member Signature _____ Date _____
MMM/DD/YYYY

This form must be received in our office within 60 days of the above date. Otherwise, a new form must be submitted.

DEPENDENT HEALTH EVIDENCE QUESTIONNAIRE

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Reason for Medical Underwriting
☐ Late Applicant (check all that apply)
☐ Spouse
☐ Child

To be completed ONLY if applying for coverage for dependents.
To avoid delays, please complete all information. All questions must be answered or form will be returned.

PLAN MEMBER INFORMATION

Group ______ Account ______ Certificate ______

Group Name ______

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

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

Phone Number (______) ______ Email ______

You acknowledge that data transmitted over the internet may be intercepted and that such transmission is at your own risk. If you no longer wish to communicate with Co-operators Life Insurance Company by email, please send notification to group_medical_uw@cooperators.ca.

Are you actively at work*? ☐ Yes ☐ No

*Actively at work means that you are able to perform all the usual and customary duties of your occupation on a full pay status and on a regular and continuous basis for the number of hours regularly scheduled for that day.

DEPENDENT INFORMATION

Spouse ______ (First Name) ______ (Initial) ______ (Last Name)

Date of Birth ______ (MMM/DD/YYYY) Sex: ☐ M ☐ F ☐ X Height ______ ☐ ft/in ☐ cm Weight ______ ☐ lbs ☐ kg

Regular Family Physician (if none, walk-in clinic visited) ______

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

Date Last Seen ______ (MMM/DD/YYYY) Reason/Outcome ______

Child ______ (First Name) ______ (Initial) ______ (Last Name)

Date of Birth ______ (MMM/DD/YYYY) Sex: ☐ M ☐ F ☐ X Height ______ ☐ ft/in ☐ cm Weight ______ ☐ lbs ☐ kg

Regular Family Physician (if none, walk-in clinic visited) ______

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

Date Last Seen ______ (MMM/DD/YYYY) Reason/Outcome ______

Child ______ (First Name) ______ (Initial) ______ (Last Name)

Date of Birth ______ (MMM/DD/YYYY) Sex: ☐ M ☐ F ☐ X Height ______ ☐ ft/in ☐ cm Weight ______ ☐ lbs ☐ kg

Regular Family Physician (if none, walk-in clinic visited) ______

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

Date Last Seen ______ (MMM/DD/YYYY) Reason/Outcome ______

Child ______ (First Name) ______ (Initial) ______ (Last Name)

Date of Birth ______ (MMM/DD/YYYY) Sex: ☐ M ☐ F ☐ X Height ______ ☐ ft/in ☐ cm Weight ______ ☐ lbs ☐ kg

Regular Family Physician (if none, walk-in clinic visited) ______

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

Date Last Seen ______ (MMM/DD/YYYY) Reason/Outcome ______

DEPENDENT INFORMATION (CONTINUED)

Do all the dependents named above reside with the employee? ☐ Yes ☐ No

Has an application for insurance on any dependent's life/health ever been declined, rated or modified? ☐ Yes ☐ No

If yes, provide details _____

HEALTH EVIDENCE

If questions 1–5 are answered "yes", please provide details in the Remarks section below.

Health care providers referred to below include physicians, specialists, nurse practitioners, psychologists, social workers, counsellors and licensed naturopaths.

1. Has any dependent ever received treatment for or seen a health care provider for any of the following?
   a. Epilepsy, seizures, multiple sclerosis, disorder of the brain or nervous system? ☐ Yes ☐ No
   b. Mental health disorders or symptoms, including depression, anxiety, bipolar disorder, post traumatic stress disorder, attention deficit hyperactivity disorder (ADHD) suicide attempts, or suicidal thoughts? ☐ Yes ☐ No
   c. High blood pressure, heart murmur, arrhythmia, palpitations, chest pain, heart attack, stroke, transient ischemic attack (TIA) or mini-stroke, aneurysm, or any other disorder of the heart or blood vessels? ☐ Yes ☐ No
   d. Hepatitis A, B, C, or type unknown? ☐ Yes ☐ No
   e. Diabetes, or sugar in the blood or urine? ☐ Yes ☐ No
   f. Leukemia, anemia, hemophilia or any disorder/ abnormality of the blood? ☐ Yes ☐ No
   g. Cancer, tumors, abnormal biopsy results, enlarged glands (nodes), skin lesions or cysts, pituitary, adrenals, or any other gland disorder? ☐ Yes ☐ No
   h. Human immunodeficiency virus (HIV) or acquired immune deficiency syndrome (AIDS)? ☐ Yes ☐ No

2. In the last 5 years, has any dependent received treatment for or seen a health care provider for any of the following?
   a. Disorder of the eyes, ears, nose or throat? ☐ Yes ☐ No
   b. Frequent headaches, head injury, dizziness or fainting? ☐ Yes ☐ No
   c. Lungs or respiratory system, such as persistent cough, asthma, emphysema, bronchitis, tuberculosis, or sleep apnea? ☐ Yes ☐ No
   d. Disorder of the stomach, gall bladder, liver, intestines, pancreas, or digestive system? ☐ Yes ☐ No
   e. Blood in the urine, kidney stones, or any other disorder of the kidney or bladder? ☐ Yes ☐ No
   f. Arthritis, gout, sciatica, disorder of the joints or limbs, any disorder of the muscles or spine, pain in the neck or back, fibromyalgia or chronic fatigue syndrome? ☐ Yes ☐ No
   g. Thyroid or other endocrine disorder? ☐ Yes ☐ No
   h. Disorder of the prostate, breasts or reproductive organs? ☐ Yes ☐ No

3. Is any dependent currently pregnant? ☐ Yes ☐ No

   If yes, please provide the expected delivery date _____ MMM/DD/YYYY

4. Is any dependent currently taking medication for a condition that you have not already disclosed on this questionnaire? ☐ Yes ☐ No

5. In the past 3 years has any dependent seen a healthcare provider for any other illness, condition, consultation or treatment that you have not disclosed on this questionnaire? ☐ Yes ☐ No

REMARKS

Details of "yes" answers for questions 1–5.

Question #	Date MMM/DD/YYYY	Details

PRIVACY

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At Co-operators, we recognize and respect the importance of privacy. When you apply for insurance or open an account with us, we will ask for your consent to collect, use, keep and share your personal information. We will explain what information we need, what we will use it for and who we will share it with. We will open a confidential file to collect, use, keep and share your personal information for the purposes of confirming your identity, reviewing your insurance needs and determining suitability of our products and services for you, assessing your application for insurance, issuing and administering your policy, including assessing and processing claims, administering your investments, meeting our contractual and regulatory obligations, detecting and preventing fraud, and performing business and statistical analysis. We will not share your personal information for other purposes, except with your consent or as required or permitted by law.

We may tell you about products and services that may be of interest to you. You can tell us what information you want to receive from us and you can withdraw your consent at any time. 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 people we have authorized who need to use it to perform their duties. This may include our third-party service providers who may use your personal information for processing, storage, analysis and disaster recovery purposes outside of your province of residence or Canada. They could be required by law to give your personal information to courts, governments or regulators outside of Canada. To protect your personal information, we ensure that privacy and security requirements are included in all third-party service provider contracts.

You can find more details about our privacy policy and how to contact our Privacy Officer at www.cooperators.ca/privacy.

APPLICANT DECLARATION AND AUTHORIZATION

Applicant Authorization and Consent

I authorize any person or organization who maintains my personal and health records or information to provide 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 Co-operators to release my personal and health information to my physician, the Public Health authorities, and Co-operator's 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 declare that any dependent children who are not my natural or adopted children have been residing with me for at least 12 consecutive months. I confirm that I am authorized to act on behalf of my spouse and dependents. I understand that 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 Co-operators voiding my insurance coverage.

Plan Member Signature _____ Date _____ MMM/DD/YYYY

Spouse Signature _____ Date _____ MMM/DD/YYYY

Child Signature _____ Date _____ MMM/DD/YYYY
(if age 16 years or more)

Child Signature _____ Date _____ MMM/DD/YYYY
(if age 16 years or more)

Child Signature _____ Date _____ MMM/DD/YYYY
(if age 16 years or more)

Any expense incurred in providing this or additional information is the responsibility of the plan member.
This form must be received in our office within 60 days of the above date. Otherwise, a new form must be submitted.

1900 ALBERT STREET REGINA SK S4P 4K8