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OPTIONAL ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE APPLICATION

GENERAL INFORMATION

Accidents happen everywhere — on the job, at home, on holidays and in many situations. This insurance provides an opportunity to purchase economical supplemental accidental death and dismemberment insurance.

HOW DOES IT WORK?

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

As an example, an individual wishes to purchase 5 units (5 x $10,000 = $50,000) of optional accidental death and dismemberment coverage.

If you choose:

Family Plan:	Your spouse will be insured for:	Your dependent children will be insured for:
	40% of your coverage (if you have children).	10% of your coverage (if you have a spouse).
	50% of your coverage (if you don't have children).	15% of your coverage (if you do not have a spouse).

Employee Plan: If the cost is $.036/1000 then, $.036 X 50 (amount of coverage being purchased/1000) = $1.80 per month.

Family Plan: If the cost is $.045/1000 then, $.045 X 50 (amount of coverage being purchased/1000) = $2.25 per month.

The schedule of losses is as follows:

100% of approved benefit:	life both hands or feet sight of both eyes one hand & one foot one hand or foot & sight of one eye use of both hands, both arms or both legs paraplegia hemiplegia quadriplegia
75% of approved benefit:	one arm or leg use of one arm or leg
50% of approved benefit:	one hand or foot sight of one eye speech hearing in both ears use of one hand
25% of approved benefit:	thumb & index finger (of same hand)
16.7% of approved benefit:	hearing in one ear

HOW DO I APPLY?

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

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

Email: **group_eligibility_administration@cooperators.ca**

Fax: **1-866-889-9924**

www.cooperators.ca/groupbenefits > Forms

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

Your premium payment is made by payroll deduction.

For more information and application forms contact your plan administrator.

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GROUP BENEFITS — OPTIONAL ACCIDENTAL DEATH & DISMEMBERMENT — INSURANCE APPLICATION

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.

Underwritten by Co-operators Life Insurance Company.

1. PLAN MEMBER INFORMATION

Group _____ Account _____ Certificate _____ Group Name _____

The beneficiary of this insurance is as designated on my enrolment form for Group Life Insurance.

Plan Member _____ (First Name) _____ (Initial) _____ (Last Name) Date of Birth _____ (MMM/DD/YYYY) Sex: ☐ M ☐ F ☐ X

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

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.

2. PLAN INFORMATION

Plan: ☐ Employee Plan ☐ Family Plan Amount of Insurance: $ _____

3. PLAN MEMBER QUESTIONS

1. Have you used marijuana, or sedative, tranquillizing, hallucinogenic or narcotic drugs, other than as prescribed by a physician? ..... ☐ Yes ☐ No

   If yes, complete the following: Type of Drug _____

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

   Date last used _____ (MMM/DD/YYYY)

2. What is your average alcohol consumption? Frequency of use: ☐ Daily ☐ Weekly ☐ Monthly ☐ Other _____

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

   Have you taken, or been advised to take, treatment or counselling for alcohol abuse (including becoming a member of Alcoholics Anonymous)? ☐ Yes ☐ No

3. Have you been treated for or had any indication of dizziness, fainting, convulsions, nervous breakdown, epilepsy, stroke or disorder of the brain or nervous system, or disorder of the eyes or ears? ..... ☐ Yes ☐ No

   If yes, specify

4. 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.

5. DECLARATION & 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