co-operators
Investments. Insurance. Advice.

GROUP BENEFITS CRITICAL DISEASE STATEMENT

CONTACT INFORMATION

Mail: Co-operators Life Insurance Company
Group Life Claims Department
1900 Albert Street
Regina SK S4P 4K8

Phone: 1-866-442-3098
Fax: 1-866-889-9925
Email: group_life_claims@cooperators.ca

PLAN SPONSOR INSTRUCTIONS

For clients not billed by 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 SPONSOR

Plan Member _____ (First Name) _____ (Initial) _____ (Last Name) Date of Birth _____ (MMM/DD/YYYY)

Group _____ Account _____ Certificate _____

Date plan member became insured under Co-operators AD&D 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) Possible Return to Work Date _____ (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

Provide any additional information which might assist us in considering this claim _____

Name of Plan Sponsor _____

Phone Number (_____)_____ Cell Number (_____)_____ Fax Number (_____) _____

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

If you would like Co-operators to communicate with you by email about this claim, please provide your 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_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)

2. PLAN MEMBER

Critical Disease/Diagnosis _____

Date of onset of symptoms _____ (MMM/DD/YYYY) Date of Diagnosis _____ (MMM/DD/YYYY)

List dates of hospitalizations from _____ (MMM/DD/YYYY) to _____ (MMM/DD/YYYY). Name of Institution _____

Provide names and addresses of attending physician(s)

Physician	Address	Date Seen MMM/DD/YYYY

EDUCATION TRAINING

Indicate the highest grade level of education completed ☐ Grade 6 or under ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ 13

Type of degree, diploma, or certificate _____

Other training, special or vocational courses _____

Plan Member _____ _____ _____
First Name | Initial | Last Name

3. PLAN MEMBER AUTHORIZATION

Co-operators Life Insurance Company 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 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 the Co-operators privacy policy at www.cooperators.ca. If you have any questions regarding our privacy policies or about how we collect, use, keep and share your personal information, please contact our Privacy Officer at Co-operators at 1-888-887-7773, or by e-mail: privacy@cooperators.ca

I hereby authorize any physician, hospital, clinic, pharmacy or any other medical or health care provider or facility, the group plan administrator and/or adjudicator or their agent, any insurance company, reinsurer, provincial health insurance plan, government department or agency, my employer or former employers, and any other person, organization or institution having any medical or other relevant personal information or records regarding me to release to and exchange with Co-operators, the group plan administrator or their representatives and/or agents, any and all such information necessary for the purposes of investigating and confirming the accuracy and validity of my claim, to determine my eligibility for benefits or to administer my claim. I understand that my refusal or withdrawal of consent may delay claims adjudication or result in the denial of my claim. I declare that the information provided in this statement and any statements provided in any personal or telephone interview relating to this claim are/will be true, complete and accurate. This authorization shall remain valid for the duration of the claim unless revoked in writing by me. Any copy of this authorization shall be as valid as the original.

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Plan Member Signature _____ Date _____
MMM/DD/YYYY

Address _____ _____ _____ _____
Street | City | Province | Postal Code

Telephone (_____) _____