co-operators
Investments. Insurance. Advice.

DIRECT DEPOSIT APPLICATION
HEALTH CARE/DENTAL PAYMENTS

To avoid delays, please complete the required information.

1. GENERAL INFORMATION

To have your claim benefits deposited electronically, simply complete the attached form and return it to us.

Direct deposit of funds allows Co-operators to deposit your benefit payments directly to your financial institution. This service is convenient for you because the money will automatically appear in your account each time a claim is paid. A corresponding explanation of benefit letter will be mailed to you explaining the distribution of the benefit payment. If you change your bank account, we require three weeks notice to avoid any delay in your payment.

You can choose to go paperless by providing your email address and banking information through Benefits Now® for Plan Members. You will receive your explanation of benefits electronically and can update your banking information online. You can register for Benefits Now for Plan Members by calling our Group Client Service Centre at 1-800-667-8164.

Please return the completed form to:

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

Fax: (306) 761-7176

2. PLAN MEMBER INFORMATION

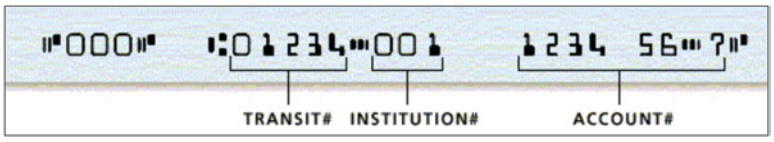
Group _____ Account _____ Certificate _____

Plan Member _____ _____ _____
First Name Initial Last Name

Address _____ _____ _____ _____
Street City Province Postal Code

Financial Institution Name _____

Please include a personal cheque marked "VOID". If you are not attaching a void cheque, please provide the following information as displayed by the example below:



Transit _____ Institution _____ Account _____
(5 digits) (3 digits) (maximum 12 digits)

3. PRIVACY & 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 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 Co-operators to deposit Extended Health and Dental payments directly to my account and to exchange my relevant financial information with my financial institution for such purpose. This authorization shall remain valid until revoked by me in writing. Any copy of this authorization shall be as valid as the original.

Plan Member Signature _____ Date _____
MMM/DD/YYYY