the co-operators®
A Better Place For You®

GROUP BENEFITS LONG TERM DISABILITY PLAN SPONSOR STATEMENT

MAILING ADDRESS

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

Fax: 1-866-889-9926

Email: disability_claims_admin@cooperators.ca

INSTRUCTIONS

Please print clearly and be sure all sections are complete to avoid delays in processing the claim.

For clients not billed by The Co-operators, please attach a copy of the plan member's enrolment form and a copy of the billing.

If illness/injury is claimed to be work related, the plan member must make an application to Workers' Compensation in addition to this plan.

1. PLAN MEMBER INFORMATION

Plan Member ______________________ (First Name) ____ (Initial) ______________________ (Last Name)

Group ______________ Account ______________ Class ______________ Certificate ______________

Date of Birth ______________ (MMM/DD/YYYY) ☐ Male ☐ Female Social Insurance Number* ______________

* Social Insurance Number is for taxable plans and any Contribution To Pension benefits.

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

Phone Number (_______)______________ Cell Number (_______) ______________

If you would like The Co-operators to communicate with you by email about this disability claim, please provide your email ______________

Co-operators Life Insurance Company uses reasonable safeguards to protect all information it collects, uses, retains and discloses in the course of conducting business. However, the Internet is not a secure medium and we do not use email encryption. As such, we cannot guarantee complete privacy and confidentiality of any email transmissions. This includes the email text and any attachments. By authorizing communication by email, you are acknowledging that you have read and understood this notice and disclaimer and are consenting to the transmission of your personal information using email knowing the email and any attachments may be subject to unauthorized access, use or disclosure by third parties. You agree that Co-operators Life Insurance Company is not responsible or liable for any damages or losses you or any other person may suffer as a result of any breach of privacy, confidentiality or security by transmission of your personal information using email communication. If you no longer wish to communicate with Co-operators Life Insurance Company by email, please send notification to disability_claims_admin@cooperators.ca.

2. COVERAGE INFORMATION

Class or union affiliation to which the plan member belongs (if applicable) ______________

Date plan member became insured under The Co-operators LTD 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) Date Returned to Work ______________ (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

If "No" please provide details. ______________

____

The plan member is ☐ Hourly ☐ Salaried ☐ Commissioned***

*** For commissioned or self employed plan members provide T4, notice of assessment, and statement of expenses for the previous two years.

The plan member is ☐ Full-time ☐ Part-time ☐ Contract (please enclose a copy of the contract agreement)

Average hours worked in a normal work week ______ (excluding overtime) What days of the week does the plan member work? ______________ (ie. Monday to Friday)

Is the plan member involved in shift work? ☐ Yes ☐ No If yes, what is the rotation schedule? ______________

Date employment terminated (if applicable) ______________ (MMM/DD/YYYY) Reason ______________

3. EARNINGS/BENEFIT INFORMATION (ATTACH COPY OF PAY STUB FOR LAST FULL PAY PERIOD)

Plan Member Gross Salary $ ______________ (exclude overtime, commissions, bonuses) ☐ Hourly ☐ Weekly ☐ Bi-weekly ☐ Semi-monthly ☐ Monthly ☐ Annually

Effective Date of Salary ______________ (MMM/DD/YYYY) Is any portion of the premium paid by the plan sponsor/employer? ☐ No (non-taxable) ☐ Yes (taxable)

Current tax exception per Federal TD1 $ ______________ (Attach TD1) (In Quebec, tax deductions are according to the latest TP-1015:3)

State regular payroll deductions for: Pension (if applicable) $ ______________ RRSP (if applicable) $ ______________

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Plan Member ______________________ ____ ______________________
First Name Initial Last Name

3. EARNINGS/BENEFIT INFORMATION (CONTINUED)

OTHER INCOME:

☐ Sick Pay	From ______ (MMM/DD/YYYY) To ______ (MMM/DD/YYYY)	☐ Vacation Pay	From ______ (MMM/DD/YYYY) To ______ (MMM/DD/YYYY)
☐ Workers Compensation	From ______ (MMM/DD/YYYY) To ______ (MMM/DD/YYYY) Status ______	☐ Employment Insurance	From ______ (MMM/DD/YYYY) To ______ (MMM/DD/YYYY) Status ______
☐ Short Term Disability	From ______ (MMM/DD/YYYY) To ______ (MMM/DD/YYYY) Status ______	☐ Other	From ______ (MMM/DD/YYYY) To ______ (MMM/DD/YYYY) Please explain ______

4. PENSION INFORMATION (IF APPLICABLE)

At the date of disability, was the plan member enrolled in one of the following plans? ☐ Yes ☐ No

☐ Defined Benefit Pension Plan ☐ Defined Contribution Pension Plan ☐ Group RRSP ☐ Individual RRSP

Administered by (financial institution or organization) ______________________

Address ______________________ ______________________ ________ ________
Street City Province Postal Code

Date plan member became or will become eligible to contribute ______________
MMM/DD/YYYY

Plan Name ______________________ Registration/Account Number ______________

Contribution levels at date of disability Employee ________% Employer ________ %

5. OCCUPATIONAL INFORMATION

What was the regular occupation of the plan member immediately prior to his/her no longer attending work? ______________________

How long has the plan member worked in this position? ______________________

Please describe this plan member's regular occupation as well as any modifications, if any. **Attach a copy of the job description provided by the company.**

____

____

When did the plan member's illness or injury first appear to affect his/her work? ______________
MMM/DD/YYYY

From your observations how did the plan member's performance change? ______________________

____

Are you able to accommodate modified: Hours ☐ Yes ☐ No Duties ☐ Yes ☐ No

Have you discussed a return to work with the plan member? ☐ Yes ☐ No If yes, provide date and details ______________
MMM/DD/YYYY

____

Has this job been eliminated? ☐ Yes ☐ No

PHYSICAL DEMANDS ANALYSIS

The following physical demands analysis of the plan member's occupation is to be completed by his/her supervisor.
In the appropriate column, please specify the average amount of time (in hours) the following activities are regularly performed:

		Continuously	Daily Total
1. Sitting			
2. Standing			
3. Driving			
4. Bending			
5. Climbing up and down stairs			
6. Lifting	☐ 0-10 lbs ☐ 10-20 lbs ☐ 20-50 lbs ☐ 50+ lbs with lifting device? ☐ Yes ☐ No		
7. Pushing/Pulling	☐ 0-10 lbs ☐ 10-20 lbs ☐ 20-50 lbs ☐ 50+ lbs		

Please describe work environment (i.e. temperature, noise levels, chemical/dust exposure, etc.) ______________________

____

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Plan Member ____________________ ______ ____________________
First Name Initial Last Name

5. OCCUPATIONAL INFORMATION (CONTINUED)

Please list any machines, tools, or other equipment that the plan member uses in the occupation ____________________

____

____

Please provide any additional information that may be relevant to this claim which has not been previously provided ____________________

____

____

6. DECLARATION

Name of Plan Sponsor ____________________

Phone Number (_______)____________ Cell Number (________) ____________ Fax Number (________) ____________

Name of Supervisor ____________________ Phone Number (________) ____________

Address ____________________ ____________ ________ ________
Street City Province Postal Code

Form completed by ____________________ Title ____________________
Name (please print)

I hereby declare that the answers to the above questions are accurate and complete.

Authorized Signature ____________________ Date ____________
MMM/DD/YYYY

Co-operators Life Insurance Company Privacy Statement

At The 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 The Co-operators at 1-888-887-7773, or by e-mail: privacy@cooperators.ca

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