co-operators
Investments. Insurance. Advice.

OPTIONAL GROUP LIFE INSURANCE APPLICATION

GENERAL INFORMATION

This brochure is designed to outline the benefits for which you are eligible and does not create or confer any contractual or other rights. All rights with respect to the benefits of an insured person will be governed solely by the group policy issued by Co-operators Life Insurance Company.

WHY DO I NEED ADDITIONAL COVERAGE?

Statistics indicate that Canadian families require insurance coverage at a level of four to six times the annual household income. One of the most valuable assets that we as individuals possess, is the ability to earn an income. Loss of income through untimely death can have a devastating effect on a family's lifestyle and dreams unless provisions are made for the replacement of lost income.

IS A MEDICAL EXAM REQUIRED?

Co-operators Life Insurance Company reserves the right to request a medical examination or other evidence at no expense to you. You will be notified directly if one is required.

WHEN DOES INSURANCE TAKE EFFECT?

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

HOW ARE PREMIUMS PAID?

Payment of premium is made by payroll deduction.

HOW DOES IT WORK?

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

As an example, a 34 year old person wishes to purchase 10 units =($100,000) of additional life coverage. If the cost of this amount of coverage under this benefit amount was $1.00 per unit per month, then: $1.00 x 10 units = $10.00 per month.

HOW DO I APPLY?

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

Co-operators Life Insurance Company
Attn: Group Medical Underwriting Department

1900 Albert Street
Regina, SK S4P 4K8

Email: group_client_services@cooperators.ca

Fax: 1-866-889-9924

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CONTACT INFORMATION

Mail: Co-operators Life Insurance Company
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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.

This form must be received in our office within 60 days of the application being signed, otherwise a new application must be completed.

PLAN MEMBER INFORMATION

Group _____ Account _____ Certificate _____ Group Name _____

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

Is plan member actively at work? ☐ Yes ☐ No If no, why? _____

APPLICANT INFORMATION

Applicant: ☐ Plan Member ☐ Spouse _____ (First Name) _____ (Initial) _____ (Last Name)

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_client_services@cooperators.ca

Phone Number: Home (_____)_____ Work (_____)_____ Cell (_____)_____

Date of Birth _____ (MMM/DD/YYYY) ☐ Male ☐ Female

Annual Salary $ _____ Occupation _____

COVERAGE AMOUNT

Existing Optional Group Life Amount: $ _____ (under this group)

New Total Amount Requested: $ _____

BENEFICIARY INFORMATION (Designation by Plan Member only)

- All changes must be initialled by the Plan Member.
- For spousal applications the beneficiary of this insurance will be the Plan Member.
- Percentage allocation will be deemed equal unless indicated otherwise. Percentages must total 100%.
- If you do not name a beneficiary, your "estate" will be the beneficiary.

PRIMARY BENEFICIARY(IES)

First Name	Initial	Last Name	Relationship	% Allocated
				%
				%

CONTINGENT BENEFICIARY*

First Name	Initial	Last Name	Relationship

*A Contingent beneficiary is applicable if the primary beneficiary predeceases the Plan Member.

Trustee* _____ (First Name) _____ (Initial) _____ (Last Name) _____ (Relationship)

*If you do not name a Trustee, the insurance proceeds will be paid to the minor beneficiary's legal guardian or into court. If a designated beneficiary is a minor, please name a Trustee. Insurance proceeds will be paid to the trustee if the beneficiary has not reached the age of majority at the time the insurance proceeds are payable.

In Quebec, the designation of your spouse as a beneficiary is irrevocable unless you declare otherwise. I designate my spouse as a revocable beneficiary: ☐ Yes

APPLICANT DECLARATION OF INSURABILITY

1. Have any family members been diagnosed with diabetes, heart disease, high blood pressure, multiple sclerosis, elevated blood fats, cancer, mental illness, HIV, or had a stroke? ☐ Yes ☐ No

   If yes, specify condition, relationship, and age at diagnosis _____

2. Have any of your parents, brothers or sisters had any hereditary disorders? ☐ Yes ☐ No

   If yes, specify (e.g. Huntington's chorea, polycystic kidney disease, etc.) _____

3. Have you had any symptoms of, or treatment for, any medical condition, disorder or ailment that resulted in your hospitalization within the last year? ☐ Yes ☐ No

   If yes, give details below:

Name of Disorder	Date of Onset	Date of Recovery	Attending Physician or Hospital	Result
	MMM/DD/YYYY	MMM/DD/YYYY		
	MMM/DD/YYYY	MMM/DD/YYYY		

4. Height _____ ☐ ft/in ☐ cm Weight _____ ☐ lbs ☐ kg

   Has your weight changed in the past year? ☐ Yes ☐ No

   If so, how much? _____ Why? _____

5. Are you now, to the best of your knowledge and belief, in good health and free from all symptoms of illness and disease? ☐ Yes ☐ No

   If no, give details below:

Name of Disorder	Date of Onset	Attending Physician or Hospital	Result
	MMM/DD/YYYY		
	MMM/DD/YYYY		

6. Are you now under observation or taking treatment or medication from any physician or alternative health care provider for any disorder, ailment or condition? (Alternative health care provider includes herbalist, acupuncturist, chiropractor or practitioner of homeopathy or naturopathy, etc.) ☐ Yes ☐ No

   If yes, what? _____ Why? _____

7. Who is your regular physician or family doctor? _____

   If none, walk-in clinic visited: _____ (Street) _____ (City) _____ (Province) _____ (Postal Code)

   Approximate Date Last Seen _____ (MMM/DD/YYYY) Reason and Result _____

8. Do you have any condition for which future hospitalization or surgery has been advised or is contemplated? ☐ Yes ☐ No

   If yes, give details and dates _____

9. Have you ever had or been told you had any of the following:

   a) Lung or respiratory disorder (e.g. asthma, bronchitis, tuberculosis, emphysema)? ☐ Yes ☐ No
   b) Heart trouble (e.g. pain in the chest, shortness of breath, high blood pressure, rheumatic fever, murmur, heart attack or stroke)? ☐ Yes ☐ No
   c) Stomach trouble (e.g. ulcer, appendicitis, gall bladder, hernia, or other digestive disorder, colitis)? ☐ Yes ☐ No
   d) Diabetes, kidney disease, sexually transmitted disease, or abnormality of the urine? ☐ Yes ☐ No
   e) Cancer, cyst, tumour, growth or blood disorder? ☐ Yes ☐ No
   f) Epilepsy, paralysis, dizziness or brain disorder? ☐ Yes ☐ No
   g) Neuritis, arthritis, rheumatism, back, spine, bone, joint, or muscle disorder? ☐ Yes ☐ No
   h) Nervous or mental disorders, including depression, anxiety or suicidal thoughts? ☐ Yes ☐ No
   i) AIDS or an AIDS related complex, or had a positive reaction to a test designed to reveal the presence of Human Immunodeficiency Virus (HIV),or any other immunological disorder? ☐ Yes ☐ No
   j) Hepatitis A,B, C or type unknown, or any other disorder of the liver? ☐ Yes ☐ No
   k) Any disease, impairment or deformity not named above? ☐ Yes ☐ No

   If yes to any question in number 9, give details below:

Name of Disorder	Date of Onset	Date of Recovery	Attending Physician or Hospital	Result
	MMM/DD/YYYY	MMM/DD/YYYY		
	MMM/DD/YYYY	MMM/DD/YYYY		

APPLICANT DECLARATION OF INSURABILITY (CONTINUED)

10. Have you ever taken drugs, including marijuana and cocaine for other than medical purposes or been advised to reduce alcohol consumption or received or have been counselled to receive treatment for drug addiction or alcoholism? ☐ Yes ☐ No

    If yes, give details including: Substance _____

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

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

11. Have you ever been refused life insurance or offered insurance modified in any way? ☐ Yes ☐ No

    If yes, date _____ (MMM/DD/YYYY) Reason _____

12. Tobacco Use: Have you smoked or used any form of tobacco, nicotine products or nicotine substitutes within the past twelve (12) months? ☐ Yes ☐ No

    If yes, for how long? _____ how many per day? _____

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 revised privacy policy at www.cooperators.ca/privacy. 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.

DECLARATION & AUTHORIZATION

APPLICANT AUTHORIZATION AND CONSENT

I have read and understood the privacy statement and I consent to the collection, use, retention and disclosure of my personal information or those of my dependants for the purposes stated above. I understand that I may revoke my consent at any time in writing and acknowledge that should I do so, my claim may not be adjudicated.

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-operators 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.

Signature _____ (Spouse Signature) Date _____ (MMM/DD/YYYY)

Signature _____ (Plan Member Signature) Date _____ (MMM/DD/YYYY)