the co-operators®
A Better Place For You®

GROUP BENEFITS
LIFE WAIVER OF PREMIUM
PLAN SPONSOR STATEMENT

FOR OFFICE USE ONLY

MAILING ADDRESS

Mail: Co-operators Life Insurance Company
Group Life Claims Department
1920 College Avenue
Regina SK S4P 1C4

Fax: 1-866-889-9925

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, a copy of the billing, and a copy of the LTD approval letter.

1. PLAN MEMBER INFORMATION

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

Group _____ Account _____ 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 (_____)_____

2. COVERAGE INFORMATION

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

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

Plan Member Gross Salary (exclude overtime, commissions, bonuses) $ _____ ☐ Hourly ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Annually
(attach copy of pay stub for last full pay period)

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

4. 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)

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

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4. OCCUPATIONAL INFORMATION (CONTINUED)

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

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.) _____

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 _____

5. 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 _____ (Name (please print)) Title _____

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
Co-operators Life Insurance Company is committed to protecting the privacy, confidentiality, accuracy and security of the personal information that it collects, uses, retains and discloses in the course of conducting business.