the co-operators®
A Better Place For You®

GROUP BENEFITS
LIFE WAIVER OF PREMIUM
PLAN MEMBER 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.

1. PLAN MEMBER INFORMATION

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

Group _____ Account _____ Certificate _____

Plan Sponsor/Employer _____ Phone Number (_____) _____

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

* If age 60 or over, enclose a copy of your birth certificate

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. CLAIM INFORMATION

Describe your present medical condition, its cause and history _____

Date Symptoms Began _____ (MMM/DD/YYYY) Date of first treatment for this illness/injury _____ (MMM/DD/YYYY)

Medical condition has prevented me from working since _____ (MMM/DD/YYYY)

Have you ever had a similar injury or illness in the past? ☐ Yes ☐ No

If yes, please describe your condition, the date of its onset, any treatment you received for it, and any time lost from work because of it.

List all physicians you have seen for your present medical condition (ensure copies of all available specialists' reports are provided):

Physician	Address	Dates Seen From	Dates Seen To	Next Appointment Date
		MMM/DD/YYYY	MMM/DD/YYYY	MMM/DD/YYYY
		MMM/DD/YYYY	MMM/DD/YYYY	MMM/DD/YYYY
		MMM/DD/YYYY	MMM/DD/YYYY	MMM/DD/YYYY

List any dates of hospitalization From _____ (MMM/DD/YYYY) To _____ (MMM/DD/YYYY)

Has your physician told you to restrict your activities in any way? ☐ Yes ☐ No

If yes, describe what he/she told you about restricting your activities _____

How do these restrictions interfere with your ability to perform your job duties? _____

Plan Member _____ _____ _____
First Name Initial Last Name

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2. CLAIM INFORMATION (CONTINUED)

Have you discussed a return to work with your employer? ☐ Yes ☐ No

☐ Own Occupation	☐ Modified Occupation	☐ Part-Time	☐ Full-Time
Date _____ MMM/DD/YYYY	Date _____ MMM/DD/YYYY	Date _____ MMM/DD/YYYY	Date _____ MMM/DD/YYYY

Have you discussed a return to work with your physician? ☐ Yes ☐ No

☐ Own Occupation	☐ Modified Occupation	☐ Part-Time	☐ Full-Time
Date _____ MMM/DD/YYYY	Date _____ MMM/DD/YYYY	Date _____ MMM/DD/YYYY	Date _____ MMM/DD/YYYY

3. OCCUPATION AND EDUCATION INFORMATION

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 _____

_____

_____

WORK EXPERIENCE

Present Employment

Occupation _____ Date Started _____ MMM/DD/YYYY

Duties _____

Previous Employment

Please complete the following, providing details of your previous positions

1. Employer _____ Job Title _____ Dates of Employment _____
   Duties _____

2. Employer _____ Job Title _____ Dates of Employment _____
   Duties _____

3. Employer _____ Job Title _____ Dates of Employment _____
   Duties _____

Job Skills

What skills have you acquired in your current and previous jobs? (e.g. typing, operation of equipment, supervisory skills, etc) Where appropriate, give level of proficiency.

_____

_____

Community Interests

Outline your past or present involvement with any community or volunteer organizations.

_____

Hobbies

_____

Plan Member _____ _____ _____
First Name Initial Last Name

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4. PRIVACY

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.

Co-operators Life Insurance Company will collect, use and disclose personal information about you, your spouse or dependents for the purposes of providing group benefit plan administration, underwriting and claim services. Only authorized personnel have access to your information, and our systems and procedures are designed to prevent the loss, misuse, unauthorized access, disclosure, alteration, or destruction of your information. Our commitment to security extends to the contracts and agreements we sign with external suppliers and service providers. Your personal information may be collected by or transferred to a service provider outside of Canada for processing, storage, analysis or disaster recovery. You can find more details about Co-operators Life Insurance Company's privacy policy at www.cooperators.ca. If you have any questions regarding our privacy policies or about the collection, use and disclosure of your personal information, please contact: The Co-operators Privacy Officer: Priory Square, Guelph ON N1H 6P8 Tel: 1-888-887-7773 email: privacy@cooperators.ca (please indicate Co-operators Life Insurance Company in your inquiry).

5. PLAN MEMBER AUTHORIZATION

I have read and understood the section entitled "Privacy" and I consent to the collection, use and disclosure of my personal information for the purposes stated. I hereby authorize any physician, hospital, clinic, pharmacy or any other medical or health care provider or facility, the group plan administrator 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, employment, vocational , financial or other relevant personal information or records regarding me to release to and exchange with Co-operators Life Insurance Company, 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, determine my eligibility for benefits, administer my claim, assess and facilitate my ability to return to work and administer the group benefits plan and coverage.

In consideration for any payment of benefits made to me by Co-operators Life Insurance Company, the policyholder, or plan administrator (the "payor"), I hereby agree to refund, in accordance with the provisions of the policy/plan document, from any source as defined under All Source Benefit and/or Other Income, any monies that may be due to the payor and further irrevocably assign all right, title, and interest of such monies and any group insurance proceeds to the payor for such purpose.

I hereby authorize Co-operators Life Insurance Company to deposit disability payments directly to my account and to exchange my relevant financial information with my financial institution for such purpose. This authorization shall remain valid for the duration of my claim unless revoked by me in writing.

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 Plan Member 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.

For Quebec residents - Under this assignment, the definition of All Source Benefits and/or Other Income does not include the benefits paid by the Commission de la santé et sécurité du travail or by the Commission des lésions professionnelles.

Plan Member Signature _____ Date _____
MMM/DD/YYYY