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PLAN MEMBER GUIDE AND APPLICATION FOR SHORT TERM DISABILITY

This guide is designed to assist you in the claim submission process.

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PLAN MEMBER GUIDE AND APPLICATION FOR SHORT TERM DISABILITY

DISABILITY BENEFITS

Disability benefits are intended to replace a portion of your salary during the period of time that you are unable to work due to an illness or injury.

You are not entitled to disability benefits automatically. Rather to qualify for disability benefits, we must determine that you are an eligible and covered plan member, you have submitted satisfactory proof of "total disability" as defined in your group insurance policy, you have completed an elimination period and you have met the terms and conditions of your group insurance policy.

THE FOLLOWING INFORMATION IS REQUIRED:

Plan Member Statement

Asks general information about you, your occupation and the nature of your disability for the purpose of assessing your claim. Please complete all questions on this form and be sure to include your group number.

Attending Physician Statement

Ask your physician to complete the form. Ensure that your physician includes copies of test results, specialist reports and any additional medical information that may assist us with your claim.

You are responsible for providing medical proof that you are entitled to receive disability benefits. Your physician may request a fee for completing claim forms which will be your responsibility. If we request information directly from your physician, we may offer to pay your physician a correspondence fee.

Plan Sponsor Statement

Ensure the Plan Sponsor Statement is submitted to our office by your employer.

CLAIM INTERVIEW

A Co-operators Life Insurance Company representative may telephone you to obtain information about your occupation, education and employment history, medical history, and current condition.

CANADA PENSION PLAN/QUEBEC PENSION PLAN (CPP/QPP) DISABILITY BENEFITS

If you have already applied for CPP/QPP disability benefits, then please include your Notice of Entitlement with your application. If you have not applied, we may require you to submit an application for CPP/QPP benefits.

WORKERS' COMPENSATION BENEFITS

If you have applied for Workers' Compensation, we still require you to apply for disability benefits under your group insurance policy. This will ensure that your claim is received within the time limits prescribed in your group insurance policy.

AUTHORIZATION AND PRIVACY

We need your permission to obtain information that will help us assess your claim. By signing the authorization request, you give Co-operators Life Insurance Company permission to obtain this information from your treatment providers, your plan sponsor, other insurers and hospitals where you received treatment.

Co-operators Life Insurance Company is committed to protecting the privacy, confidentiality, accuracy and security of the personal information it collects, uses, retains and discloses in the course of conducting business. Co-operators Life Insurance Company will abide by all federal and provincial privacy legislation which governs the protection of all personal information in it custody. For further information regarding Co-operators Life Insurance Company privacy policies, please refer to your booklet or our website at www.cooperators.ca/en/PublicPages/Privacy.aspx

CONTACT INFORMATION

If you have any questions or if you need help with your disability claim, please contact your plan administrator or our office at 1-866-442-3098. Please have your group policy and certificate number available.

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GROUP BENEFITS
SHORT TERM DISABILITY
PLAN MEMBER STATEMENT

FOR OFFICE USE ONLY

MAILING ADDRESS

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

Fax: 1-866-889-9926

INSTRUCTIONS

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

If illness/injury is claimed to be work related, you 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 _____ Certificate _____

Plan Sponsor/Employer _____ Phone Number (_____) _____

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

*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 _____ Date of first treatment for this illness/injury _____
MMM/DD/YYYY 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.

_____

_____

_____

If your condition is the result of an injury or motor vehicle accident, please describe the events surrounding the injury/accident

Date _____ Time _____
MMM/DD/YYYY

Details _____

_____

a) Was this a work related injury? ☐ Yes ☐ No

b) Was another party at fault? ☐ Yes ☐ No

c) Was alcohol involved in the events surrounding the accident? ☐ Yes ☐ No

d) Was it reported to the police? ☐ Yes ☐ No

If yes, attach a copy of the police report

e) Were any charges laid? ☐ Yes ☐ No

f) Are you pursuing a claim for wage loss against a third party? ☐ Yes ☐ No

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

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2. CLAIM INFORMATION (CONTINUED)

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? _____

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

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

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

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

OTHER INCOME:

Have you applied for, or are you receiving the following:
(Attach copies of all correspondence you have received)

	I have applied	I am receiving	Date Applied	Effective Date	Amount
Workers' Compensation	☐ Yes ☐ No	☐ Yes ☐ No	MMM/DD/YYYY	MMM/DD/YYYY	$ _____ per week/bi-weekly
Canada Pension Retirement	☐ Yes ☐ No	☐ Yes ☐ No	MMM/DD/YYYY	MMM/DD/YYYY	$ _____ per month
Disability	☐ Yes ☐ No	☐ Yes ☐ No	MMM/DD/YYYY	MMM/DD/YYYY	$ _____ per month
Car Insurance	☐ Yes ☐ No	☐ Yes ☐ No	MMM/DD/YYYY	MMM/DD/YYYY	$ _____ per week/month
Employment Insurance	☐ Yes ☐ No	☐ Yes ☐ No	MMM/DD/YYYY	MMM/DD/YYYY	$ _____ per week/month
Other: _____ (please describe)	☐ Yes ☐ No	☐ Yes ☐ No	MMM/DD/YYYY	MMM/DD/YYYY	$ _____ per week/month

3. OCCUPATION INFORMATION

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 _____

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

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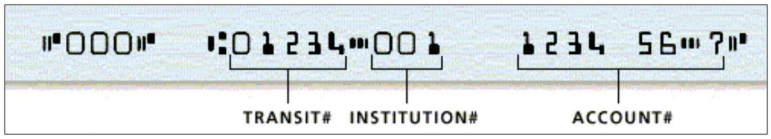
4. DIRECT DEPOSIT (TO ISSUE A PAYMENT, WE REQUIRE COMPLETION OF THIS SECTION)

Direct deposit of funds allows Co-operators Life Insurance Company to deposit your disability benefits directly to your financial institution. The funds will be deposited within 1 – 3 business days.

Financial Institution _____

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 ☐☐☐☐☐ (5 digits) Institution ☐☐☐ (3 digits) Account ☐☐☐☐☐☐☐☐☐☐☐☐ (maximum 12 digits)

5. 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).

6. 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