



# **LIVING ASSISTANCE<sup>®</sup> BENEFIT PLAN MEMBER AGREEMENT AND APPLICATION**

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

# LIVING ASSISTANCE® BENEFIT PLAN MEMBER AGREEMENT AND APPLICATION

## LIVING ASSISTANCE® BENEFIT

The Living Assistance® benefit is available as an advanced life insurance payment to help meet the expenses of terminally ill plan members who have coverage under the group life insurance plan.

To be eligible, you must meet **ALL** of the following criteria:

- be terminally ill with a life expectancy of 12 months or less as diagnosed by your physician;
- be at least 2 years younger than the age at which your insurance would normally terminate under the Group Life insurance policy or be age 63, whichever is lesser; and
- be approved for a life waiver of premium.

The amount available as a Living Assistance benefit is outlined in your group insurance booklet. If your basic Group Life insurance benefit is based on the number of your dependents, the Living Assistance benefit will be calculated excluding your dependents.

We advise you to contact Canada Revenue Agency regarding the taxability of this benefit.

Upon your death, your beneficiary will receive a payment based on the remaining amount payable under your Group Life insurance benefit, which is derived after deducting your advance payment and any accrued interest. Please inform your beneficiary about your Living Assistance benefit and its terms.

If you live longer than two years from the date of your application, Co-operators Life Insurance Company may require you to pay back any advanced payments including interest.

Co-operators Life Insurance Company will contact your physicians or treatment providers to request information related to your claim under the Living Assistance benefit.

## AUTHORIZATION AND PRIVACY

Co-operators Life Insurance Company needs to obtain your personal information to determine your eligibility, assess your application and administer or process your claim. By signing and submitting your Plan Member Agreement and Application to Co-operators Life Insurance Company, you consent to us obtaining information from your treatment providers, plan sponsor, other insurers and hospitals or facilities 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. We comply with all applicable privacy legislation governing the protection, collection, retention, use and disclosure of your personal information. For further information regarding our privacy policy, please refer to your booklet or our website at [www.cooperators.ca/en/PublicPages/Privacy.aspx](http://www.cooperators.ca/en/PublicPages/Privacy.aspx)

## CONTACT INFORMATION

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

## PLAN MEMBER AGREEMENT AND APPLICATION

FOR OFFICE USE ONLY

### MAILING ADDRESS

### INSTRUCTIONS

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

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

Fax: 1-866-889-9925

### 1. PLAN MEMBER INFORMATION

Group \_\_\_\_\_ Account \_\_\_\_\_ Certificate \_\_\_\_\_

Plan Member \_\_\_\_\_  
First Name Initial Last Name

Address \_\_\_\_\_  
Street City Province Postal Code

Plan Sponsor/Employer \_\_\_\_\_ Phone Number (\_\_\_\_\_) \_\_\_\_\_

### 2. CLAIM INFORMATION

Diagnosis \_\_\_\_\_ Date of Diagnosis \_\_\_\_\_  
MMM/DD/YYYY

Provide the names and addresses of two physicians who are treating you with respect to your current condition.

Physician	Address	Phone Number	Fax Number
1)			
2)			

### 3. AUTHORIZATION AND DECLARATION

**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.

I am applying for an advanced payment of my Life insurance under the Living Assistance® benefit ("Advanced Payment") and consent to Co-operators Life Insurance Company (the "Insurer") collecting, using and disclosing my personal information in order to determine my eligibility, assess my application and process my claim.

I understand that by receiving and using the Advanced Payment, I am agreeing to the following terms:

- The amount of my Basic Life insurance benefit under the group insurance contract will be reduced by the amount of the Advanced Payment and any accrued interest;
- I will be charged interest at the current settlement interest rate plus 1% on the amount of the Advanced Payment, with the interest rate subject to change monthly;
- Upon my death, the Insurer will pay my beneficiary any remaining amount under my Group Life insurance policy, the remainder of which is derived after deducting the Advanced Payment I received and any accrued interest calculated from the date I received the Advanced Payment to the date of my death;
- Should the Living Assistance benefit be found a taxable benefit under the applicable *Income Tax Act*, I or my estate will be responsible for paying any applicable taxes on the Advanced Payment;
- Should I live longer than 2 years from the date of this application, the Insurer may require me to pay back the Advanced Payment I received with any accrued interest; and
- If I do not pay back the Advanced Payment within 2 years of the date of this application, then, upon Co-operators Life Insurance Company's demand for payment, I will pay the Insurer the specified amount plus any accrued interest.

I hereby authorize and direct any physician, hospital, clinic, facility or any other medical or health care provider, the group plan administrator and/or adjudicator or their agent or representative, any insurance company, reinsurer, provincial health insurance plan, government department or agency, and any other person, organization, association or institution having information, records or knowledge about me or my health to disclose, release, share and exchange information with Co-operators Life Insurance Company, the group plan administrator and/or adjudicator or their agent or representative any and all such information necessary for the purposes of determining my eligibility, assessing my application, investigating and confirming the accuracy and validity of my claim, and administering or processing my claim. The authorization and direction I provided herein shall be good and sufficient authority, and any copy of this completed form is as valid as the original. My consent and authorization shall remain valid for the duration of my claim unless I revoke these in writing.

By signing this form, I confirm reading and understanding this form in its entirety and declare my statements above, including all other past and future statements made through personal or telephone interviews relating to my claim, to be true, complete, current and accurate.

Plan Member Signature \_\_\_\_\_ Date \_\_\_\_\_  
MMM/DD/YYYY