the co-operators
A Better Place For You®

# GROUP BENEFITS NOTICE OF DEATH 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 and a copy of the billing.

If the sum insured is based on salary, please attach a copy of the plan member's pay stub for the last full pay period.

## 1. PLAN MEMBER INFORMATION

Plan Member ______________________ (First Name) ____ (Initial) ______________________ (Last Name)

Group ______________ Account ______________ Certificate ______________

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

* If age is over 60, please attach a copy of the plan member's birth certificate

Date of Employment ______________ (MMM/DD/YYYY) Date Last Worked ______________ (MMM/DD/YYYY)

If plan member has been absent from work for more than 1 week, please provide reason ______________

Plan Member occupation as of date last worked ______________

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

The plan member is ☐ Hourly ☐ Salaried ☐ Commissioned The plan member is ☐ Full-time ☐ Part-time

## 2. CLAIM INFORMATION

Death of: ☐ Plan Member ☐ Dependent Relationship to Plan Member ______________

Name of Deceased ______________________ (First Name) ____ (Initial) ______________________ (Last Name)

Date of Death ______________ (MMM/DD/YYYY)

## 3. EARNINGS/BENEFIT INFORMATION (ATTACH COPY OF PAY STUB FOR LAST FULL PAY PERIOD)

Plan Member Gross Salary $ ______________ (exclude overtime, commissions, bonuses) ☐ Hourly ☐ Weekly ☐ Bi-weekly ☐ Semi-monthly ☐ Monthly ☐ Annually

Effective Date of Salary ______________ (MMM/DD/YYYY)

## 4. DECLARATION

Name of Plan Sponsor ______________

Phone Number ( ____ )______________ Cell Number ( ____ )______________ Fax 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.