the co-operators®
A Better Place For You®

GROUP BENEFITS DISMEMBERMENT STATEMENT

FOR OFFICE USE ONLY

MAILING ADDRESS

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

Fax: 1-866-889-9925

PLAN SPONSOR INSTRUCTIONS

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 SPONSOR

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

Group _____ Account _____ Certificate _____

Date of Birth _____ (MMM/DD/YYYY)

Date plan member became insured under The Co-operators AD&D policy _____ (MMM/DD/YYYY) **and** with a previous carrier's policy _____ (MMM/DD/YYYY)

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

Provide any additional information which might assist us in considering this claim _____

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)

2. PLAN MEMBER

Loss for which you are claiming _____

Is loss due to:

☐ **Disease** Date of Diagnosis _____ (MMM/DD/YYYY)

OR

☐ **Accident** Date of Accident _____ (MMM/DD/YYYY) Time _____ ☐ a.m. ☐ p.m. Location of Accident _____ (City) _____ (Province)

Describe the circumstances surrounding the accident _____

_____

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

Did the accident involve another party? ☐ Yes ☐ No If yes, provide the name of the other party/parties involved in the accident

Name _____ Address _____

Name _____ Address _____

Was it reported to the police? ☐ Yes ☐ No If yes, attach a copy of the police report.

Were any charges laid? ☐ Yes ☐ No If yes, against whom? _____

What were the charges? _____

Plan Member _____ _____ _____
First Name Initial Last Name

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2. PLAN MEMBER (CONTINUED)

List dates of hospitalizations from _____ to _____. Name of Institution _____
MMM/DD/YYYY MMM/DD/YYYY

Provide names and addresses of attending physician(s)

Physician	Address	Date Seen
		_____ MMM/DD/YYYY
		_____ MMM/DD/YYYY
		_____ MMM/DD/YYYY

3. PLAN MEMBER AUTHORIZATION

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 hereby authorize any physician, hospital, clinic, pharmacy or any other medical or health care provider or facility, the group plan administrator and/or adjudicator 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 or other relevant personal information or records regarding me to release to and exchange with Co-operators, 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, to determine my eligibility for benefits or to administer my claim. I authorize the use of my Social Insurance Number for the purposes of tax reporting and for the identification and administration of any benefits. 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 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.

Plan Member Signature _____ Date _____
MMM/DD/YYYY

Address _____ _____ _____ _____
Street City Province Postal Code

Telephone (_____) _____