the co-operators®
A Better Place For You®

GROUP BENEFITS
LONG TERM DISABILITY
PLAN SPONSOR 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.

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 illness/injury is claimed to be work related, the plan member 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 _____

Date of Birth _____ (MMM/DD/YYYY) ☐ Male ☐ Female 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. COVERAGE INFORMATION

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

Date plan member became insured under The Co-operators LTD 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

If "No" please provide details. _____

_____

The plan member is ☐ Hourly ☐ Salaried ☐ Commissioned***

*** For commissioned or self employed plan members provide T4, notice of assessment, and statement of expenses for the previous two years.

The plan member is ☐ Full-time ☐ Part-time ☐ Contract (please enclose a copy of the contract agreement)

Average hours worked in a normal work week _____ (excluding overtime) What days of the week does the plan member work? _____ (ie. Monday to Friday)

Is the plan member involved in shift work? ☐ Yes ☐ No If yes, what is the rotation schedule? _____

Date employment terminated (if applicable) _____ (MMM/DD/YYYY) Reason _____

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) Is any portion of the premium paid by the plan sponsor/employer? ☐ No (non-taxable) ☐ Yes (taxable)

Current tax exception per Federal TD1 $_____ (Attach TD1) (In Quebec, tax deductions are according to the latest TP-1015:3)

State regular payroll deductions for: Pension (if applicable) $ _____ RRSP (if applicable) $ _____

OTHER INCOME:

☐ Sick Pay	From _____ (MMM/DD/YYYY)	To _____ (MMM/DD/YYYY)	☐ Vacation Pay	From _____ (MMM/DD/YYYY)	To _____ (MMM/DD/YYYY)
☐ Workers Compensation	From _____ (MMM/DD/YYYY)	To _____ (MMM/DD/YYYY)	☐ Employment Insurance	From _____ (MMM/DD/YYYY)	To _____ (MMM/DD/YYYY)
	Status _____			Status _____	
☐ Short Term Disability	From _____ (MMM/DD/YYYY)	To _____ (MMM/DD/YYYY)	☐ Other	From _____ (MMM/DD/YYYY)	To _____ (MMM/DD/YYYY)
	Status _____			Please explain _____	

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

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4. PENSION INFORMATION (IF APPLICABLE)

At the date of disability, was the plan member enrolled in one of the following plans? ☐ Yes ☐ No

☐ Defined Benefit Pension Plan ☐ Defined Contribution Pension Plan ☐ Group RRSP ☐ Individual RRSP

Administered by (financial institution or organization) _____

Address _____ _____ _____ _____
Street | City | Province | Postal Code

Date plan member became or will become eligible to contribute _____
MMM/DD/YYYY

Plan Name _____ Registration/Account Number _____

Contribution levels at date of disability Employee _____% Employer _____ %

5. OCCUPATIONAL INFORMATION

What was the regular occupation of the plan member immediately prior to his/her no longer attending work? _____

How long has the plan member worked in this position? _____

Please describe this plan member's regular occupation as well as any modifications, if any. **Attach a copy of the job description provided by the company.**

_____

_____

When did the plan member's illness or injury first appear to affect his/her work? _____
MMM/DD/YYYY

From your observations how did the plan member's performance change? _____

_____

Are you able to accommodate modified: Hours ☐ Yes ☐ No Duties ☐ Yes ☐ No

Have you discussed a return to work with the plan member? ☐ Yes ☐ No If yes, provide date and details _____
MMM/DD/YYYY

_____

Has this job been eliminated? ☐ Yes ☐ No

PHYSICAL DEMANDS ANALYSIS

The following physical demands analysis of the plan member's occupation is to be completed by his/her supervisor.
In the appropriate column, please specify the average amount of time (in hours) the following activities are regularly performed:

		Continuously	Daily Total
1. Sitting			
2. Standing			
3. Driving			
4. Bending			
5. Climbing up and down stairs			
6. Lifting	☐ 0-10 lbs ☐ 10-20 lbs ☐ 20-50 lbs ☐ 50+ lbs with lifting device? ☐ Yes ☐ No		
7. Pushing/Pulling	☐ 0-10 lbs ☐ 10-20 lbs ☐ 20-50 lbs ☐ 50+ lbs		

Please describe work environment (i.e. temperature, noise levels, chemical/dust exposure, etc.) _____

_____

_____

Please list any machines, tools, or other equipment that the plan member uses in the occupation _____

_____

_____

Please provide any additional information that may be relevant to this claim which has not been previously provided _____

_____

_____

Plan Member _____ _____ _____
First Name Initial Last Name

6. DECLARATION

Name of Plan Sponsor _____

Phone Number (_____)_____ Cell Number (_____) _____ Fax Number (_____) _____

Name of Supervisor _____ Phone Number (_____) _____

Address _____ _____ _____ _____
Street City Province Postal Code

Form completed by _____ Title _____
Name (please print)

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.

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