the co-operators®
A Better Place For You®

GROUP BENEFITS
LONG TERM DISABILITY
PLAN MEMBER STATEMENT

MAILING ADDRESS	INSTRUCTIONS
Mail: Co-operators Life Insurance Company Disability Claims Department 1920 College Avenue Regina SK S4P 1C4 Fax: 1-866-889-9926	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

Group _____ Account _____ Certificate _____

Plan Member _____ _____ _____
First Name Initial Last Name

Address _____ _____ _____ _____
Street City Province Postal Code

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

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

* If age 60 or over, enclose a copy of your birth certificate ** Social Insurance Number is for taxable plans and any Contribution To Pension benefits.

Plan Sponsor/Employer _____ Telephone (_____) _____

If you would like The Co-operators to communicate with you by email about this disability claim, please provide your email _____

Co-operators Life Insurance Company uses reasonable safeguards to protect all information it collects, uses, retains and discloses in the course of conducting business. However, the internet is not a secure medium and we do not use email encryption. As such, we cannot guarantee complete privacy and confidentiality of any email transmissions. This includes the email text and any attachments. By authorizing communication by email, you are acknowledging that you have read and understood this notice and disclaimer and are consenting to the transmission of your personal information using email knowing the email and any attachments may be subject to unauthorized access, use or disclosure by third parties. You agree that Co-operators Life Insurance Company is not responsible or liable for any damages or losses you or any other person may suffer as a result of any breach of privacy, confidentiality or security by transmission of your personal information using email communication. If you no longer wish to communicate with Co-operators Life Insurance Company by email, please send notification to Disability_Claims_Admin@cooperators.ca

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

Date last worked due to medical condition _____
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

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 (MMM/DD/YYYY)	Dates Seen To (MMM/DD/YYYY)	Next Appointment Date (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 (MMM/DD/YYYY)	Effective Date (MMM/DD/YYYY)	Amount
Workers' Compensation	☐ Yes ☐ No	☐ Yes ☐ No			$ per week/bi-weekly
Canada Pension Retirement	☐ Yes ☐ No	☐ Yes ☐ No			$ per month
Disability	☐ Yes ☐ No	☐ Yes ☐ No			$ per month
Car Insurance	☐ Yes ☐ No	☐ Yes ☐ No			$ per week/month
Employment Insurance	☐ Yes ☐ No	☐ Yes ☐ No			$ per week/month
Other: _____ (please describe)	☐ Yes ☐ No	☐ Yes ☐ No			$ per week/month

3. OCCUPATION AND EDUCATION INFORMATION

EDUCATION TRAINING

Indicate the highest grade level of education completed ☐ Grade 6 or under ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ 13

Type of degree, diploma, or certificate _____

Other training, special or vocational courses _____

WORK EXPERIENCE

Present Employment

Occupation _____ Date Started _____ (MMM/DD/YYYY)

Duties _____

Plan Member _____ _____ _____
First Name Initial Last Name

3. OCCUPATION AND EDUCATION INFORMATION (CONTINUED)

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 _____

Job Skills

What skills have you acquired in your current and previous jobs? (e.g. typing, operation of equipment, supervisory skills, etc) Where appropriate, give level of proficiency.

_____

_____

Community Interests

Outline your past or present involvement with any community or volunteer organizations.

_____

Hobbies

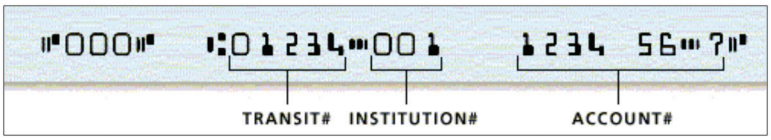
_____

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).

PLEASE SEE PAGE 6 FOR YOUR SIGNATURE AND AUTHORIZATION

Plan Member _____ _____ _____
First Name Initial Last Name

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