

**MAILING ADDRESS**

Mail: Co-operators Life Insurance Company  
Group Life Claims  
1900 Albert Street  
Regina SK S4P 4K8  
  
Fax: 1-866-889-9925

**INSTRUCTIONS**

The plan member is responsible for the cost of completing this form.  
Medical Information is to be completed by the physician providing treatment.

**1. PLAN MEMBER INFORMATION & AUTHORIZATION (TO BE COMPLETED BY THE PLAN MEMBER)**

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

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

Plan Sponsor/Employer Name \_\_\_\_\_ Telephone Number (\_\_\_\_\_) \_\_\_\_\_

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

I hereby authorize my physician to release any medical information supporting my claim for disability benefits to the plan administrator, the plan adjudicator and my insurer. I understand that I am responsible for obtaining this form and for any amounts charged by my physician to complete this form.

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

**2. MEDICAL INFORMATION (TO BE COMPLETED BY THE PHYSICIAN)**

**Please attach copies of chart notes, test results, and consultation reports.**

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

2. If an accident \_\_\_\_\_  
MMM/DD/YYYY

Nature of injury (location and extent) \_\_\_\_\_  
\_\_\_\_\_

Date of first treatment for this injury \_\_\_\_\_  
MMM/DD/YYYY

3. Dismemberment  Hand  Foot  Arm  Leg  Finger  
If applicable, please use diagram indicating loss and level of amputation.

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

Was amputation necessary as a result of the accident/disease indicated above?  Yes  No

4. Loss of use  Hand  Arm  Foot  Leg  Paraplegia  Hemiplegia  Quadriplegia  
Did the accident/disease result in total and irrecoverable loss of use/paralysis?  Yes  No

If yes, provide details \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Has the loss of use/paralysis been continuous for 12 months?  Yes  No

5. Loss of  Vision  Speech  Hearing  
Percentage of loss \_\_\_\_\_%

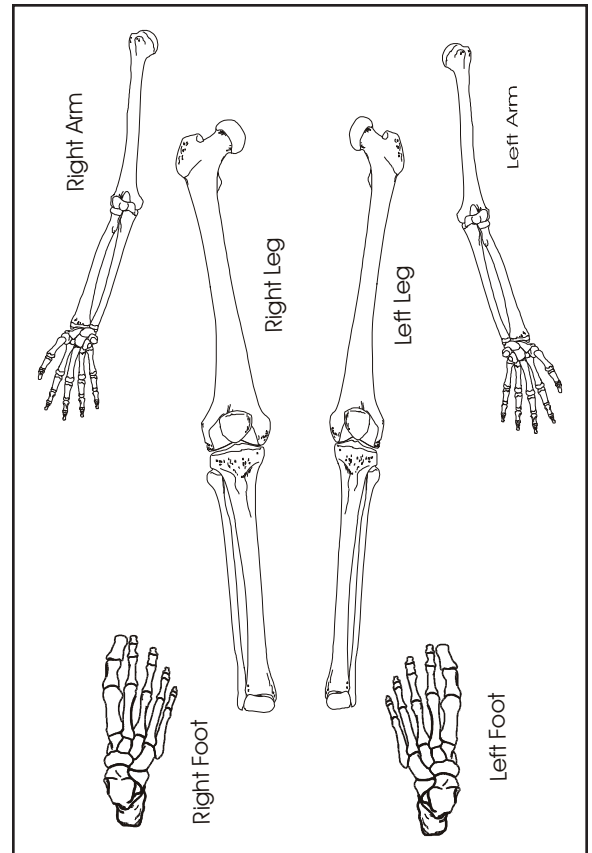
Will vision, speech or hearing be recovered or partially recovered by the use of a device or rehabilitative program?  Yes  No

If yes, provide details \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date on which loss of sight occurred \_\_\_\_\_ If accident/disease required removal of eye, date \_\_\_\_\_  
MMM/DD/YYYY MMM/DD/YYYY

Vision in each eye prior to accident/disease: Right \_\_\_\_\_ Left \_\_\_\_\_ Present vision, if any, in each eye: Right \_\_\_\_\_ Left \_\_\_\_\_

6. Was the accident/disease described above solely responsible for the loss?  Yes  No  
If no, provide details of any contributing cause(s) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



### 3. PHYSICIAN ACKNOWLEDGEMENT AND AUTHORIZATION

I acknowledge that the information in this statement will be kept in a disability benefits file with the plan insurer and might be accessible by the patient or third parties to whom access has been granted or those authorized by law. By providing the information I consent to such unedited release by any information contained herein.

If you would like The Co-operators to communicate with you by email about this 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 [Group\\_life\\_claims@cooperators.ca](mailto:Group_life_claims@cooperators.ca).

Attending Physician (Please Print) \_\_\_\_\_

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

Certified Speciality \_\_\_\_\_ Family Physician  Yes  No

Phone Number ( \_\_\_\_\_ ) \_\_\_\_\_ Fax Number ( \_\_\_\_\_ ) \_\_\_\_\_

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_  
MMM/DD/YYYY

Physician's Stamp

### 4. PRIVACY

#### Co-operators Life Insurance Company Privacy Statement

At The Co-operators, we recognize and respect the importance of privacy. When you apply for insurance or open an account with us, we will ask for your consent to collect, use, keep and share your personal information. We will explain what information we need, what we will use it for and who we will share it with. We will open a confidential file to collect, use, keep and share your personal information for the purposes of confirming your identity, reviewing your insurance needs and determining suitability of our products and services for you, assessing your application for insurance, issuing and administering your policy, including assessing and processing claims, administering your investments, meeting our contractual and regulatory obligations, detecting and preventing fraud, and performing business and statistical analysis. We will not share your personal information for other purposes, except with your consent or as required or permitted by law.

We may tell you about products and services that may be of interest to you. You can tell us what information you want to receive from us and you can withdraw your consent at any time. You may access and correct, if needed, the personal information in your file by sending us a request in writing.

We limit access to your personal information to our staff and other people we have authorized who need to use it to perform their duties. This may include our third-party service providers who may use your personal information for processing, storage, analysis and disaster recovery purposes outside of Canada. They could be required by law to give your personal information to courts, governments or regulators outside of Canada. To protect your personal information, we ensure that privacy and security requirements are included in all third-party service provider contracts.

You can find more details about The Co-operators privacy policy at [www.cooperators.ca](http://www.cooperators.ca). If you have any questions regarding our privacy policies or about how we collect, use, keep and share your personal information, please contact our Privacy Officer at The Co-operators at 1-888-887-7773, or by e-mail: [privacy@cooperators.ca](mailto:privacy@cooperators.ca)