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PLAN MEMBER GUIDE AND APPLICATION FOR LONG TERM DISABILITY

This guide is designed to assist you in the claim submission process.

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PLAN MEMBER GUIDE AND APPLICATION FOR LONG TERM DISABILITY

DISABILITY BENEFITS

Disability benefits are intended to replace a portion of your salary during the period of time that you are unable to work due to an illness or injury.

You are not entitled to disability benefits automatically. Rather to qualify for disability benefits, we must determine that you are an eligible and covered plan member, you have submitted satisfactory proof of "total disability" as defined in your group insurance policy, you have completed an elimination period and you have met the terms and conditions of your group insurance policy.

Please check with your plan sponsor or your benefit booklet to confirm your elimination period as that determines when to submit your claim.

Elimination Period	When To Submit
Less than 60 days	Immediately after the date last worked
More than 60 days	Six weeks before the end of your elimination period

THE FOLLOWING INFORMATION IS REQUIRED:

Plan Member Statement

Asks general information about you, your occupation and the nature of your disability for the purpose of assessing your claim. Please complete all questions on this form and be sure to include your group number.

Attending Physician Statement

Ask your physician to complete the Attending Physician Statement form specific to your primary diagnosis. There are two forms, one for mental health conditions and one for all other conditions. Ensure that your physician includes copies of test results, specialist reports and any additional information that may assist us with your application.

You are responsible for providing medical proof that you are entitled to receive disability benefits. Your physician may request a fee for completing claim forms which will be your responsibility. If we request information directly from your physician, we may offer to pay your physician a correspondence fee.

Plan Sponsor Statement

Ensure the Plan Sponsor Statement is submitted to our office by your employer.

CLAIM INTERVIEW

A Co-operators Life Insurance Company representative may telephone you to obtain information about your occupation, education and employment history, medical history, and current condition.

CANADA PENSION PLAN/QUEBEC PENSION PLAN (CPP/QPP) DISABILITY BENEFITS

If you have already applied for CPP/QPP disability benefits, then please include your Notice of Entitlement with your application. If you have not applied, we may require you to submit an application for CPP/QPP benefits.

WORKERS' COMPENSATION BENEFITS

If you have applied for Workers' Compensation, we still require you to apply for disability benefits under your group insurance policy. This will ensure that your claim is received within the time limits prescribed in your group insurance policy.

AUTHORIZATION AND PRIVACY

We need your permission to obtain information that will help us assess your claim. By signing the authorization request, you give Co-operators Life Insurance Company permission to obtain this information from your treatment providers, your plan sponsor, other insurers and hospitals where you received treatment.

Co-operators Life Insurance Company is committed to protecting the privacy, confidentiality, accuracy and security of the personal information it collects, uses, retains and discloses in the course of conducting business. Co-operators Life Insurance Company will abide by all federal and provincial privacy legislation which governs the protection of all personal information in it custody. For further information regarding Co-operators Life Insurance Company privacy policies, please refer to your booklet or our website at www.cooperators.ca/en/PublicPages/Privacy.aspx

CONTACT INFORMATION

If you have any questions or if you need help with your disability claim, please contact your plan administrator or our office at 1-866-442-3098. Please have your group policy and certificate number available.

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GROUP BENEFITS
LONG TERM DISABILITY
PLAN MEMBER STATEMENT

MAILING ADDRESS

Mail: Co-operators Life Insurance Company
Disability Claims Department
1900 Albert Street
Regina, SK S4P 4K8

Fax: 1-866-889-9926

INSTRUCTIONS

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)	To	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

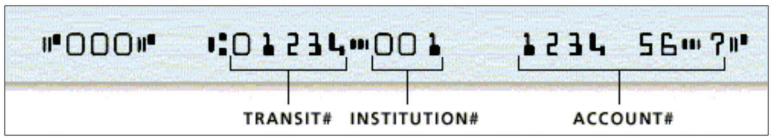
_____

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

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. 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

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