



PLAN MEMBER GUIDE AND APPLICATION FOR LONG TERM DISABILITY

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

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 its 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.

GROUP BENEFITS LONG TERM DISABILITY PLAN MEMBER STATEMENT

MAILING ADDRESS	INSTRUCTIONS
Mail: Co-operators Life Insurance Company Disability Claims Department 1900 Albert Street Regina, SK S4P 4K8 Fax: 1-866-889-9926 Email: disability_claims_admin@cooperators.ca	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

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 MMM/DD/YYYY		Next Appointment Date MMM/DD/YYYY
		From	To	

List any dates of hospitalization From _____ To _____
MMM/DD/YYYY 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 Modified Occupation Part-Time Full-Time
 Date _____ Date _____ Date _____ Date _____
MMM/DD/YYYY MMM/DD/YYYY MMM/DD/YYYY MMM/DD/YYYY

Have you discussed a return to work with your physician? Yes No

Own Occupation Modified Occupation Part-Time Full-Time
 Date _____ Date _____ Date _____ Date _____
MMM/DD/YYYY MMM/DD/YYYY MMM/DD/YYYY 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	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			\$ per week/bi-weekly
Canada Pension Retirement	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			\$ per month
Disability	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			\$ per month
Car Insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			\$ per week/month
Employment Insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			\$ per week/month
Other: _____ (please describe)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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 _____

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