

# GROUP BENEFITS SHORT TERM DISABILITY PLAN SPONSOR STATEMENT

## MAILING ADDRESS

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

## 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 \_\_\_\_\_ Class \_\_\_\_\_ Certificate \_\_\_\_\_

Date of Birth \_\_\_\_\_  Male  Female Social Insurance Number\* \_\_\_\_\_  
MMM/DD/YYYY

\* Social Insurance Number is for taxable plans and any Contribution To Pension benefits.

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

Phone Number ( \_\_\_\_\_ ) \_\_\_\_\_ Cell Number ( \_\_\_\_\_ ) \_\_\_\_\_

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. COVERAGE INFORMATION

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

Date plan member became insured under The Co-operators STD policy \_\_\_\_\_ **and** with a previous carrier's policy \_\_\_\_\_  
MMM/DD/YYYY MMM/DD/YYYY

Date of Employment \_\_\_\_\_ Date Last Worked \_\_\_\_\_ Date Returned to Work \_\_\_\_\_  
MMM/DD/YYYY MMM/DD/YYYY 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\*\*\* The plan member is  Full-time  Part-time

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

Average hours worked in a normal work week \_\_\_\_\_ What days of the week does the plan member work? \_\_\_\_\_  
(excluding overtime) (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) \_\_\_\_\_ Reason \_\_\_\_\_  
MMM/DD/YYYY

## 3. EARNINGS/BENEFIT INFORMATION (ATTACH COPY OF PAY STUB FOR LAST FULL PAY PERIOD)

Plan Member Gross Salary \$ \_\_\_\_\_  Hourly  Weekly  Bi-weekly  Semi-monthly  Monthly  Annually  
(exclude overtime, commissions, bonuses)

Effective Date of Salary \_\_\_\_\_ Is any portion of the premium paid by the plan sponsor/employer?  No (non-taxable)  Yes (taxable)  
MMM/DD/YYYY

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

**3. EARNINGS/BENEFIT INFORMATION (CONTINUED)**

**OTHER INCOME:**

<input type="checkbox"/> Sick Pay	From _____ <small>MMM/DD/YYYY</small>	To _____ <small>MMM/DD/YYYY</small>	<input type="checkbox"/> Vacation Pay	From _____ <small>MMM/DD/YYYY</small>	To _____ <small>MMM/DD/YYYY</small>
<input type="checkbox"/> Workers Compensation	From _____ <small>MMM/DD/YYYY</small>	To _____ <small>MMM/DD/YYYY</small>	<input type="checkbox"/> Employment Insurance	From _____ <small>MMM/DD/YYYY</small>	To _____ <small>MMM/DD/YYYY</small>
	Status _____			Status _____	
<input type="checkbox"/> Other	Please explain _____			From _____ <small>MMM/DD/YYYY</small>	To _____ <small>MMM/DD/YYYY</small>

**4. 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.**

\_\_\_\_\_  
 \_\_\_\_\_

**5. 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 \_\_\_\_\_  
Name (please print) Title

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**

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)