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A Better Place For You®

LIVING ASSISTANCE® BENEFIT PLAN MEMBER AGREEMENT AND APPLICATION

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

GL1444 (05/20)

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LIVING ASSISTANCE® BENEFIT

The Living Assistance® benefit is available as an advanced life insurance payment to help meet the expenses of terminally ill plan members who have coverage under the group life insurance plan.

To be eligible, you must meet **ALL** of the following criteria:

- be terminally ill with a life expectancy of 12 months or less as diagnosed by your physician;
- be at least 2 years younger than the age at which your insurance would normally terminate under the Group Life insurance policy *or* be age 63, whichever is lesser; and
- be approved for a life waiver of premium.

The amount available as a Living Assistance benefit is outlined in your group insurance booklet. If your basic Group Life insurance benefit is based on the number of your dependents, the Living Assistance benefit will be calculated excluding your dependents.

We advise you to contact Canada Revenue Agency regarding the taxability of this benefit.

Upon your death, your beneficiary will receive a payment based on the remaining amount payable under your Group Life insurance benefit, which is derived after deducting your advance payment and any accrued interest. Please inform your beneficiary about your Living Assistance benefit and its terms.

If you live longer than two years from the date of your application, Co-operators Life Insurance Company may require you to pay back any advanced payments including interest.

Co-operators Life Insurance Company will contact your physicians or treatment providers to request information related to your claim under the Living Assistance benefit.

AUTHORIZATION AND PRIVACY

Co-operators Life Insurance Company needs to obtain your personal information to determine your eligibility, assess your application and administer or process your claim. By signing and submitting your Plan Member Agreement and Application to Co-operators Life Insurance Company, you consent to us obtaining information from your treatment providers, plan sponsor, other insurers and hospitals or facilities 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. We comply with all applicable privacy legislation governing the protection, collection, retention, use and disclosure of your personal information. For further information regarding our privacy policy, 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 life 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 LIVING ASSISTANCE® PLAN MEMBER AGREEMENT AND APPLICATION

MAILING ADDRESS

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

Fax: 1-866-889-9925

INSTRUCTIONS

Please print clearly and be sure all sections are complete to avoid delays in processing the claim.

1. PLAN MEMBER INFORMATION

Group 799 Account 00001 Certificate _____

Plan Member _____ (First Name) _____ (Initial) _____ (Last Name)

Address _____ (Street) _____ (City) _____ (Province) _____ (Postal Code)

Plan Sponsor/Employer _____ Phone Number (_____) _____

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.

2. CLAIM INFORMATION

Diagnosis _____ Date of Diagnosis _____ (MMM/DD/YYYY)

Provide the names and addresses of two physicians who are treating you with respect to your current condition.

Physician	Address	Phone Number	Fax Number
1)			
2)			

3. 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

4. AUTHORIZATION AND DECLARATION

I am applying for an advanced payment of my Life insurance under the Living Assistance® benefit ("Advanced Payment") and consent to Co-operators Life Insurance Company (the "Insurer") collecting, using and disclosing my personal information in order to determine my eligibility, assess my application and process my claim.

I understand that by receiving and using the Advanced Payment, I am agreeing to the following terms:

- The amount of my Basic Life insurance benefit under the group insurance contract will be reduced by the amount of the Advanced Payment and any accrued interest;
- I will be charged interest at the current settlement interest rate plus 1% on the amount of the Advanced Payment, with the interest rate subject to change monthly;
- Upon my death, the Insurer will pay my beneficiary any remaining amount under my Group Life insurance policy, the remainder of which is derived after deducting the Advanced Payment I received and any accrued interest calculated from the date I received the Advanced Payment to the date of my death;
- Should the Living Assistance benefit be found a taxable benefit under the applicable *Income Tax Act*, I or my estate will be responsible for paying any applicable taxes on the Advanced Payment;
- Should I live longer than 2 years from the date of this application, the Insurer may require me to pay back the Advanced Payment I received with any accrued interest; and
- If I do not pay back the Advanced Payment within 2 years of the date of this application, then, upon Co-operators Life Insurance Company's demand for payment, I will pay the Insurer the specified amount plus any accrued interest.

I hereby authorize and direct any physician, hospital, clinic, facility or any other medical or health care provider, the group plan administrator and/or adjudicator or their agent or representative, any insurance company, reinsurer, provincial health insurance plan, government department or agency, and any other person, organization, association or institution having information, records or knowledge about me or my health to disclose, release, share and exchange information with Co-operators Life Insurance Company, the group plan administrator and/or adjudicator or their agent or representative any and all such information necessary for the purposes of determining my eligibility, assessing my application, investigating and confirming the accuracy and validity of my claim, and administering or processing my claim. The authorization and direction I provided herein shall be good and sufficient authority, and any copy of this completed form is as valid as the original. My consent and authorization shall remain valid for the duration of my claim unless I revoke these in writing.

By signing this form, I confirm reading and understanding this form in its entirety and declare my statements above, including all other past and future statements made through personal or telephone interviews relating to my claim, to be true, complete, current and accurate.

Plan Member Signature _____ Date _____
MMM/DD/YYYY