co-operators
Investments. Insurance. Advice.

GROUP BENEFITS
OVER-AGE DEPENDENT COVERAGE APPLICATION

The intent of this product is to cover overage dependents who are unable to obtain gainful employment, an education that would support employment and have no option/opportunity for improvement.

CONTACT INFORMATION

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

Email: group_client_services@cooperators.ca

Phone: 1-800-667-8164

Fax: 1-866-889-9924

INSTRUCTIONS

To avoid delays, please complete all information.

The completed form can be returned by email, fax, or the original can be mailed to the address provided.

PLAN MEMBER INFORMATION

Group _____ Account _____ Certificate _____

Group Name _____

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

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

Phone Number (_____) _____

Email _____

You acknowledge that data transmitted over the internet may be intercepted and that such transmission is at your own risk. If you no longer wish to communicate with Co-operators Life Insurance Company by email, please send notification to group_client_services@cooperators.ca

DEPENDENT INFORMATION

Dependent _____ (First Name) _____ (Initial) _____ (Last Name)

Birth Date _____ (MMM/DD/YYYY) Sex ☐ M ☐ F

1. Please describe the nature of the disability/condition and severity

_____

2. Has the dependant ever been employed? ☐ Yes ☐ No

   If yes, give details. Please provide dates, weekly hours, description of employment and duties.

_____

3. Has the dependent ever attended school? ☐ Yes ☐ No

   If yes, give details. Please provide dates, weekly hours and type of school.

_____

4. Does the dependent's disability/condition prevent them from ever sustaining gainful employment? ☐ Yes ☐ No

   If yes, give details

_____

5. Who is your dependent's regular family physician (if none, Walk In Clinic visited)? _____

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

   Approximate Date Last Seen _____ (MMM/DD/YYYY) Reason/Outcome _____

ATTENDING PHYSICIAN STATEMENT

Please do not include in your response any information relating to genetic testing (ie. any test that analyses DNA, RNA or chromosomes for purposes such as the prediction of disease or vertical transmission risks, or monitoring, diagnosis or prognosis.

1. Please indicate the condition/diagnosis and age at diagnosis _____

   Severity: ☐ Mild ☐ Moderate ☐ Severe ☐ Profound

   ☐ Permanent ☐ Temporary

2. Has the applicant ever been diagnosed with or required medication for the treatment of depression or other mental illness? ☐ Yes ☐ No

   If yes, give details _____

3. Does the applicant require assistance/supervision with activities of daily living? ☐ Yes ☐ No

   If yes, give details _____

4. Does the applicant have impairments in Physical functioning? ☐ Yes ☐ No

   Are the impairments permanent: ☐ Yes ☐ No

   If the impairments are not permanent, when are they expected to resolve or improve? _____

5. Does the applicant have impairments in Cognitive functioning? ☐ Yes ☐ No

   Are the Impairments permanent: ☐ Yes ☐ No

   If the impairments are not permanent, when are they expected to resolve or improve? _____

   Please describe the nature and severity of any cognitive impairments

   _____

6. Does the dependent's disability/condition prevent them from ever sustaining gainful employment? ☐ Yes ☐ No

   If yes, please provide details _____

7. Please provide any additional information regarding the condition in which you feel will be helpful in processing the application.

Physician _____ _____ Specialty _____
First Name Last Name

Address _____ _____ _____ _____
Street City Province Postal Code

Phone Number (_____) _____

Physician Signature _____ Date _____
MMM/DD/YYYY

DECLARATION AND AUTHORIZATION

Applicant Authorization and Consent

I authorize any person or organization who maintains my personal and health records or information to provide Co-operators (or its agents, representatives, and administrators) with my personal and health information for the purpose of underwriting my application for insurance coverage, evaluating my eligibility for any insurance coverage, and adjudicating my insurance claim(s). I authorize Co-operators to release my personal and health information to my physician, the Public Health authorities, and Co-operator's re-insurer(s), when requested. This authorization will remain valid unless I revoke it in writing. A copy of this authorization will be as effective as the original.

Applicant Acknowledgement and Declaration

I declare that any dependent children who are not my natural or adopted children have been residing with me for at least 12 consecutive months. I confirm that I am authorized to act on behalf of my spouse and dependents. I understand that Co-operators (or its agent, representatives, and administrators) may ask me to undergo a medical or paramedical examination(s) to evaluate my eligibility for insurance coverage. If I refuse to undergo such examination(s), this may result in the delay or denial of my application for insurance coverage. I acknowledge that any information I disclose in any paramedical or medical examination or on any medical evidence form(s), questionnaire(s) or other statement(s) given as evidence of insurability will form part of my application for insurance coverage. I certify and declare that I have disclosed true, complete, and accurate information on my application for insurance coverage. I understand and acknowledge that a failure to disclose true, complete and accurate information or a misrepresentation of any material fact(s) may result in Co-operators voiding my insurance coverage.

Plan Member Signature _____ Date _____
MMM/DD/YYYY

Dependent Signature _____ Date _____
MMM/DD/YYYY

Any expense incurred in providing this or additional information is the responsibility of the plan member.
This form must be received in our office within 60 days of the above date. Otherwise, a new form must be submitted.

PRIVACY

Co-operators Privacy Statement

At 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 your province of residence or 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 our privacy policy and how to contact our Privacy Officer at www.cooperators.ca/privacy.

1900 ALBERT STREET REGINA SK S4P 4K8