the co-operators
A Better Place For You®

GROUP BENEFITS PLAN MEMBER ENROLMENT FORM

To avoid delays, please complete the required information by printing clearly in ink.

1. EMPLOYMENT INFORMATION

To be completed by the Plan Administrator

The Plan Administrator must confirm eligibility prior to completing this form based on the required hours of your benefit plan.

If enrolment is not made on time, coverage may be limited or denied based on proof of insurability. Late Applicants must complete and attach the Health Evidence Questionnaire (GL1364).

Retain a copy for your records

Group ______________ Account ___________ Class _____________ Certificate __________________

Group Name ____

Employment Commenced ___________________ (MMM/DD/YYYY) ☐ Full-time ☐ Part-time ☐ Contract

Salary $ _______ Hrs per week _____ ☐ Hourly ☐ Weekly ☐ Bi-weekly ☐ Semi-monthly ☐ Monthly ☐ Annually

Occupation __________________ Province of Residence _________ Province of Employment _________

☐ Health Spending Account (if applicable) Deposit Amount $ ________________

Signature ____ Date __________________ (MMM/DD/YYYY)

Plan Administrator Email ______________________________ Phone Number (_______) _____________

2. PLAN MEMBER INFORMATION

To be completed by the Plan Member

Common-Law Spouse means that I have lived with this person as my spouse or partner for a continuous period of at least 12 months, and I have publicly represented this person to be my common-law spouse.

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

Address ______________________ (Street) ____________ (City) ____________ (Province) ____________ (Postal Code)

Date of Birth __________________ (MMM/DD/YYYY) ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married/Civil Union ☐ *Common-Law/Partnered

* I have been living with my common-law/partner since: __________________ (MMM/DD/YYYY)

3. REFUSAL OF BENEFITS

To be completed by the Plan Member

To add these benefits at a later date, you must apply for coverage within 31 days of loss of spousal coverage. After 31 days, proof of insurability may be required and coverage may be restricted or denied.

All changes must be initialled by the Plan Member.

Coverage for Extended Health Care and Dental can be refused if you and/or your dependents have similar coverage through your spouse's employer. I understand the group benefits offered to me, but **I decline** to participate in:

Extended Health Care for: ☐ Myself and my dependents ☐ My dependents only

Dental for: ☐ Myself and my dependents ☐ My dependents only

Spouse's Insurer ____

4. DEPENDENT INFORMATION

To be completed by the Plan Member

This information is required if your plan includes Extended Health Care, Dental and/or Dependent Life coverage.

If there are more than four dependents, please attach a separate list.

** You are required to complete a Group Health Evidence questionnaire once the disabled dependent reaches the dependent age maximum as listed in the policy.

You must notify Co-operators Life Insurance Company if there are any changes in student status. You must verify your child's student status by submitting confirmation of enrolment by August 15th of each year.

Spouse ______________________ (First Name) _____ (Initial) ______________________ (Last Name)

Date of Birth __________________ (MMM/DD/YYYY) ☐ Male ☐ Female

ELIGIBLE DEPENDENT(S)

__________________ (First Name) _____ (Initial) __________________ (Last Name) Date of Birth ______________ (MMM/DD/YYYY)

☐ Male ☐ Female ☐ Post-secondary Student ☐ Disabled Dependent**

__________________ (First Name) _____ (Initial) __________________ (Last Name) Date of Birth ______________ (MMM/DD/YYYY)

☐ Male ☐ Female ☐ Post-secondary Student ☐ Disabled Dependent**

__________________ (First Name) _____ (Initial) __________________ (Last Name) Date of Birth ______________ (MMM/DD/YYYY)

☐ Male ☐ Female ☐ Post-secondary Student ☐ Disabled Dependent**

__________________ (First Name) _____ (Initial) __________________ (Last Name) Date of Birth ______________ (MMM/DD/YYYY)

☐ Male ☐ Female ☐ Post-secondary Student ☐ Disabled Dependent**

4. DEPENDENT INFORMATION (CONTINUED)

If Co-ordination of Benefits is terminated or changed, notification is required within 31 days.

CO-ORDINATION OF BENEFITS

Please check if you and your dependent(s) are eligible for the following benefits from another source or company:

☐ Extended Heath Care and Dental Coverage ☐ Extended Health Care Coverage ONLY ☐ Dental Coverage ONLY

5. BENEFICIARY INFORMATION

To be completed by the Plan Member

Percentage allocation will be deemed equal unless indicated otherwise. Percentages must total 100%.

If you do not name a beneficiary, your "estate" will be the beneficiary.

A contingent beneficiary is applicable if the primary beneficiary predeceases the Plan Member.

All changes must be initialled by the Plan Member.

If you do not name a trustee, the insurance proceeds will be paid to the minor beneficiary's legal guardian or into court.

PRIMARY BENEFICIARY(IES)

% Allocated

_____ (First Name) _____ (Initial) _____ (Last Name) _____ (Relationship) _____%

_____ (First Name) _____ (Initial) _____ (Last Name) _____ (Relationship) _____%

CONTINGENT BENEFICIARY

% Allocated

_____ (First Name) _____ (Initial) _____ (Last Name) _____ (Relationship) _____%

If a designated beneficiary is a minor, please name a Trustee. Insurance proceeds will be paid to the trustee if the beneficiary has not reached the age of majority at the time the insurance proceeds are payable

Trustee _____ (First Name) _____ (Initial) _____ (Last Name) _____ (Relationship)

In Quebec, the designation of your spouse as a beneficiary is irrevocable unless you declare otherwise. I designate my spouse as a revocable beneficiary: ☐ Yes

6. PRIVACY

CO-OPERATORS LIFE INSURANCE COMPANY PRIVACY STATEMENT

The Co-operators is committed to protecting the privacy, confidentiality, accuracy and security of the personal information that it collects, uses, retains and discloses in the course of conducting business.

At The Co-operators, we recognize and respect the importance of privacy. When you enrol for insurance coverage or submit a claim, we establish a confidential file and collect, use and disclose your personal information for the purposes of issuing, administering, adjudicating and/or servicing your insurance. 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 persons we have authorized who have a need to know it to perform their duties. Our systems and procedures are designed to prevent the loss, misuse, unauthorized access, disclosure, alteration, or destruction of your information. Our commitment to security extends to the contracts and agreements we sign with external suppliers and service providers. We may store or process your personal information in Canada, the United States or other countries for processing, storage, analysis or disaster recovery and, under applicable law, governments, courts, law enforcement or regulatory agencies, may, by lawful order, obtain disclosure of your personal information. 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 the collection, use and disclosure of your personal information, please contact our Privacy Officer at The Co-operators at Priory Square, Guelph, ON, N1H 6P8, Tel: 1-888-887-7773, E-mail: privacy@cooperators.ca (please include The Co-operators company you deal with in your inquiry).

If you do not agree with our use and disclosure of your information in connection with your application and servicing any policy that we issue, we will not be able to offer you the insurance product you are interested in, service your insurance or adjudicate your claim.

7. PLAN MEMBER SIGNATURE

To be signed by the Plan Member

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 apply for group benefits coverage and authorize the deduction from my pay and remittance to The Co-operators any contributions required under the group benefits plan. I hereby authorize the employer, group plan administrator, The Co-operators or their agents, or any other person or organization having any relevant information regarding me, my spouse or dependents to release and exchange all information necessary for the purposes of determination of eligibility for benefits and administration of the group benefits plan. I confirm I am authorized to act on behalf of my spouse and/or dependents for such purposes. I declare that the information provided is true, complete and accurate. Any copy of this authorization shall be as valid as the original.

Signature _____ Date _____ (MMM/DD/YYYY)