the co-operators®
A Better Place For You®

STUDENT ELIGIBILITY FORM

Please complete the information by printing clearly, in ink. In order to avoid delays, please ensure that all required information is provided.

1. GENERAL INFORMATION

This section is mandatory

Effective Date of Change _____ (MMM/DD/YYYY)

Group _____ Account _____ Certificate _____

Group Name _____

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

2. DEPENDENT INFORMATION

Verification of student status must be submitted by August 15th of each year of enrolment.

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

Student Status: ☐ Full-time

Student is enrolled for the school year _____ (MMM/DD/YYYY) and ending _____ (MMM/DD/YYYY)

Will student be graduating at the end of the school year indicated above? ☐ Yes* ☐ No

* If yes, coverage will terminate at the end of the semester or dependent maximum age whichever is earliest.

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

Student Status: ☐ Full-time

Student is enrolled for the school year _____ (MMM/DD/YYYY) and ending _____ (MMM/DD/YYYY)

Will student be graduating at the end of the school year indicated above? ☐ Yes* ☐ No

* If yes, coverage will terminate at the end of the semester or dependent maximum age whichever is earliest.

3. PRIVACY AND PLAN MEMBER SIGNATURE

CO-OPERATORS LIFE INSURANCE COMPANY PRIVACY STATEMENT

Co-operators Life Insurance Company is committed to protecting the privacy, confidentiality, accuracy and security of the personal information that itcollects, uses, retains and discloses in the course of conducting business.

Co-operators Life Insurance Company will collect, use and disclose personal information about you, your spouse or dependents for the purposes of providing group benefit plan administration, underwriting and claim services. Only authorized personnel have access to your information, and 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. Your personal information may be collected by or transferred to a service provider outside of Canada for processing, storage, analysis or disaster recovery. You can find more details about Co-operators Life Insurance Company's 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: The Co-operators Privacy Officer: Priory Square, Guelph ON N1H 6P8 Tel: 1-888-887-7773 email: privacy@cooperators.ca (please indicate Co-operators Life Insurance Company in your inquiry)

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 Co-operators any contributions required under the group benefits plan. I hereby authorize the employer, group plan administrator, 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.

Plan Member Signature _____ Date _____ (MMM/DD/YYYY)

Group New Business and Administration
CO-OPERATORS LIFE INSURANCE COMPANY
1920 COLLEGE AVENUE REGINA SK S4P 1C4