the co-operators

CO-OPERATORS LIFE INSURANCE COMPANY

EXTENDED HEALTH CLAIM FORM

INSTRUCTIONS

1. Attach original receipts being claimed.
2. Complete the section headed “Description of Expenses”.
3. Include a copy of the “Physician’s Recommendation”, if required.
4. Part 2 must be completed.

ASSIGNMENT OF BENEFITS

I hereby assign any benefits payable for eligible services or medical supplies provided by: ____________, ____________, ____________, ____________, and authorize direct payment to said provider/s.

X ______________________
Employee’s/Member’s Signature

PART 1 DESCRIPTION OF EXPENSES (Attach Original Receipts)

NAME OF PERSON INCURRING EXPENSE	DATE OF BIRTH D / M / Y	RELATIONSHIP	DESCRIPTION OF EXPENSE	DATE EXPENSE INCURRED D / M / Y	AMOUNT PAID

PART 2 EMPLOYEE/MEMBER STATEMENT (Please Print)

Group Policy No.	Account No.	Certificate/id#	Name of Employer/Policyholder

1. Employee’s/Members’s name: ______ (first) ______ (initial) ______ (last) Previous name (if applicable): ______
2. Employee’s/Members’s mailing address: ______ (Street) ______ (City) ______ (Prov) ______ (PostalCode)
   ☐ Check here if this is a change of address.
3. Date of Birth ____ D / ____ M / ____ Y
4. Have you (your dependent) any other coverage which would pay a benefit for this claim? ☐ Yes ☐ No
   If “YES”, name company or source: ______ Spouse’s date of birth ____ D / ____ M / ____ Y
   If coordination of benefits no longer applies, indicate termination date ____ D / ____ M / ____ Y
5. If your Plan provides a Health Spending Account, should any unpaid balance of this claim be reimbursed under your account? ☐ Yes ☐ No
6. Is claimant: ☐ student ☐ handicapped
   If claimant is a student over the age 18, name of school: ______
   Student status: ☐ Full-time ☐ Part-time ☐ Correspondence. Enrolled in the semester starting ______ (date) and ending ______ (date).
   Will student be graduating at the end of the semester indicated? ☐ Yes ☐ No

Retain photocopies of your receipts for your records

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 it collects, uses, retains and discloses in the course of conducting business.

I certify that the information contained herein is true, complete and accurate and that each of the listed expenses was purchased and/or incurred in connection with medical treatment of the above-named individuals. I acknowledge that the submission of false or incomplete information may result in the delay or denial of this claim. I authorize any physician, dentist or any health care provider and/or facility, any insurance company, benefit service provider and any other person or organization having any medical or other relevant personal information regarding me or my spouse and/or dependant to release to and exchange with Co-operators, the group plan administrator or their representatives and/or agents any and all information necessary to investigate and confirm the accuracy and validity of this claim, determine eligibility for benefits and/or administer the claim and group benefit plan. I confirm that I am authorized to act on behalf of my spouse and/or dependants for such purposes. Any copy of this authorization shall be as valid as the original.

X ______________________ Employee’s/Member’s Signature

X ______________________ Date (D/M/Y)

PART 3 EMPLOYER/POLICYHOLDER (Only If Authorization Required)

Employee’s/Member’s Effective Date D / M / Y	Dependant’s Effective Date D / M / Y	Termination Date(if applicable) D / M / Y
/ /	/ /	/ /
Signature of Employer/Plan Administrator Official X	Classification	Date D / M / Y / /

INCOMPLETE INFORMATION WILL MEAN A DELAY IN THE PROCESSING OF THE CLAIM. RETURN COMPLETED FORM TO:

HEALTH CLAIMS, THE CO-OPERATORS, 1920 COLLEGE AVENUE, REGINA SK S4P 1C4