Please refer to our website for full details / more information

www.healthcareproviders.ca

Who is HCP?

The Health Care Providers is a unique program of true group benefits specifically designed for part-time and casual hospital employees and all hospital retirees. Unlike virtually any other group plan, it is available to individual employees and their families on a voluntary basis. While employees at any hospital may join the plan, only employees of endorsing hospitals will be offered guaranteed coverage at our "Complete" level.

The plan was launched in 1997 at the Oshawa General Hospital (now Lakeridge Health Oshawa) and has grown to include over 85 endorsing hospital systems in the Province of Ontario. Endorsing sites range from small hospitals like Lady Dunn in Wawa to Sunnybrook in Toronto. The plan is underwritten by The Cooperators (Life, ADD&D and LTD) and Green Shield Canada (Health, Drug and Dental). Communication and plan design are done by the parent company, HMA The BENEFITS People of Whitby, Ontario. The administration is done by Green Shield Canada in association with HMA The BENEFITS People.

The plan offers options which include Life Insurance, Accidental Death, Disease and Dismemberment and Long Term Disability as well as health, drugs, hospital, Out of Country medical, vision, audio, paramedical services and two dental plans which are optional. There are three levels of extended health care coverage and at least one level is guaranteed with no medical evidence to all eligible enrollees. The Optimum level of coverage is provided at no additional premium to those who qualify medically.

There are four basic programs with several options in each. The first is our spousal waiver designed for individuals currently covered under a spouse's (or other) group

health plan. One is designed for individuals working 18 hours or more per week on average. Hours at other hospitals may be included in the calculation and the average is taken over the period of a year. Next is a plan for those working less than 18 hours on average or having taken retirement pre-age 65. Finally, there is a program for those ages 65 or older whether retiring or continuing with active employment. There are no life-time maximums, no deductibles and no upper age limit on the Plan 65+. The Deluxe out of country coverage in the retiree plan is very popular as it is available in open windows without medical evidence, has no pre-existing condition clause and offers 60 day trip coverage with $1 Million per year and 100% coinsurance.

The plan is portable and flexible: individuals may keep their benefits once on the plan even if they work in other hospitals, in other provinces or outside the health care field. The plan pricing is very stable mostly due to our excellent growth and annual rate increases have historically been very minimal across the board.

Our Plans

Plan 1

Eligibility

- 18 or more hours worked per week on average
- Under age 65
- Permanent* Part-time, or Casual Employee

Benefits

- Extended Health Care Benefits
- Dental Care Benefits (Optional)
- Employee Life Insurance
- Employee Accidental Death, Disease and Dismemberment Insurance
- Employee Long Term Disability Benefits

Plan 1A

Eligibility

- Currently covered under another group plan for Extended Health Care benefits
- 18 or more hours worked per week on average
- Under age 65
- Permanent* Part-time, or Casual Employee

Benefits

- Employee Life Insurance
- Employee Accidental Death, Disease and Dismemberment Insurance
- Employee Long Term Disability Benefits

Plan 2

Eligibility

- Less than 18 hours worked per week on average
- Under age 65
- Retiree, Temporary or Contract employee**

Benefits

- Extended Health Care Benefits
- Dental Care Benefits (Optional)

Plan 65+

Eligibility

- Age 65 or older
- Retiree, Temporary or Contract employee**

Benefits

- Extended Health Care Benefits
- Dental Care Benefits (Optional)

*Permanent - a position for which there is NO end date. **Temporary or contract - employment which has a set end date at the time of hire. These employees, regardless of hours worked per week, are eligible only for Plan 2.

All enrollees MUST be actively at work; not off on any leave such as maternity or disability

Guaranteed Coverage

Our health and dental care coverage is GUARANTEED. No medical questionnaire is required regardless of age, time of application, employment at an Endorsing Hospital or medical history.

Endorsing Hospital?

Yes

- 60 Day Window?
  - **Yes** → **Complete Level Health Care Coverage & Core Benefits***
  - **No** → **Essential Level Health Care Coverage**

No → **Essential Level Health Care Coverage**

Core Benefits:

Employee Life Insurance, Long Term Disability Benefits and Accidental Death, Disease and Dismemberment

* where applicable

60 Day Window:

Unique 60 day time frame during which an eligible employee will be offered the Complete level of coverage with no questions asked.

Eg. 60 days from hire, loss of Full Time Benefits, loss of other group health benefits or reaching age 65

Endorsing Hospital:

Hospital which actively communicates the opportunity for eligible employees as well as retirees to enroll in the HCP Plan.

Please refer to our website for full details / more information

www.healthcareproviders.ca

Nov. 2017 E&OE

Additional, Optional and Excess Coverage

Employees have the opportunity to apply for a variety of additional and excess coverage options. This coverage is medically underwritten and impacts the total monthly premium.

See coverage options below and see Form 4 for detailed rate information.

AVAILABLE OPTIONS

Optional Additional Life Insurance

- Employee
- Convertible
- Purchase in units of $10,000
- Purchase to a maximum of $500,000

Optional Life Insurance

- Spouse and/or Child
- Spouse convertible, child non-convertible
- Spouse: apply for coverage in units of $10,000 to a maximum of $500,000
- Child: apply for coverage in units of $5,000 to a maximum of $50,000

Long Term Disability Income

- Employee only
- Purchase in units of $100
- Purchase up to a total of 65% of your salary to a maximum benefit of $5,000 a month (this maximum includes the $1,000 Basic Coverage which is offered in Plan 1A and Plan 1)

Coverage Options and Limitations

(Applies to the benefits below which are included in Plan 1A, Plan 1 and all optional, additional and excess benefits)

Employee Life Insurance, Employee Accidental Death, Disease and Dismemberment

All Group Life Insurance coverage ceases when you retire, leave the hospital, turn 65 years of age or transfer to Plan 2. This life insurance can be converted, without medical evidence if done within 31 days of coverage termination.

Employee Long Term Disability Income

The benefit begins paying after your Employment Insurance (EI) Disability payments cease. The benefit pays all the way to age 65, as long as you remain disabled - as defined in the master policy. Definition of Disability: 2 year own occupation from date of disability; thereafter any occupation. Payments from this plan are paid tax free. Primary CPP/QPP offset (i.e.: payments received from CPP/QPP will reduce monthly benefit from this plan). Pre-existing condition limitation follows the 90/90/12 condition - as defined in the master policy. This coverage ceases when you retire, leave the hospital, turn 65 years of age, or transfer to Plan 2. Benefit Adjustment: Your benefit will be adjusted so that your total disability income from all sources will not exceed 85% of your pre-disability net income.

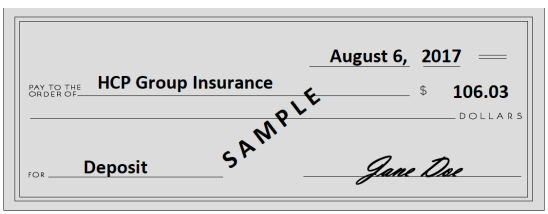
Premium Payment

A deposit and a first month premium payment is required with each enrollment. Both payments are equal to the monthly premium for the plan into which you are enrolling.

Following your enrollment, ongoing monthly premium payments are made by pre-authorized, automatic debit from the chequing account of your choice on your last pay day each month and are used to pay for your coverage for the following month.

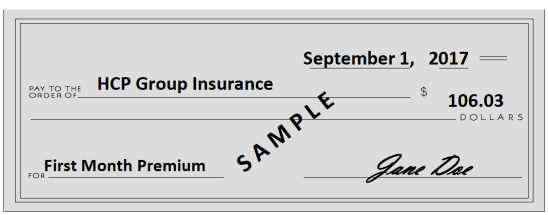
1. Deposit Cheque

Deposit cheques are dated the day you complete the enrollment forms and WILL be cashed when the enrollment forms are received. This cheque is NOT VOID. The amount should be equal to the monthly premium for the plan into which you are enrolling. The amount will be held for the duration of time you are covered under the HCP plan and may be used to pay for your last month's premium should you choose to cancel OR may serve to ensure there is no disruption in your coverage should we not be able to collect payment from you in any given month - ie. insufficient funds.



2. First Month Premium Cheque

First Month Premium Cheques are dated for the first of the month in which your coverage will begin. This cheque is NOT VOID. The amount should be equal to the monthly premium for the plan into which you are enrolling. This amount will be used to cover the cost of your first month of coverage under the plan. Each monthly premium following your first month will be drawn from the same account on your last pay day each month and will cover the following month's coverage.



Don't Use Cheques?

We do offer alternate solutions for making Deposit and First Month Premium payments. Please contact us toll free at 1.866.768.1477 for further details or refer to our website for full details / more information **www.healthcareproviders.ca**

Plans Details

	Plan 1A*	Plan 1*			Plan 2			Plan 65+		
Core Coverage										
Life Insurance	$10,000	$10,000			X			X		
Long Term Disability	$1,000/month	$1,000/month			X			X		
Accidental Death, Disease & Dismemberment	$25,000	$25,000			X			X		
COVERAGE LEVEL	†GUARANTEED	†GUARANTEED		MEDICAL QUESTIONS ASKED	†GUARANTEED		MEDICAL QUESTIONS ASKED	†GUARANTEED		MEDICAL QUESTIONS ASKED
		Essential	Complete	Optimum	Essential	Complete	Optimum	Essential	Complete	Optimum
Co-insurance	N/A	70%	80%	100%	70%	80%	100%	70%	80%	80%
Annual Plan Maximum	N/A	$5,000	N/A	N/A	$5,000	N/A	N/A	$5,000	$7,500	$10,000
Extended Heath Care Coverage										
Prescription Drugs	X	$750	$1,000	$10,000 90%	$750	$1,000	$10,000 90%	X	$2,500	Unlimited 90%
Out of Country Travel	X	$1,000,000 100%	$1,000,000 100%	$1,000,000	$1,000,000 100%	$1,000,000 100%	$1,000,000	$1,000,000 100%	$1,000,000 100%	$1,000,000 100%
Trip Cancellation	X	X	X	X	X	X	X	$5,000 100%	$5,000 100%	$5,000 100%
Hospital Accommodations	X	X	$3,000 100%	$5,000	X	$3,000 100%	$5,000	X	7 Day Maximum 100%	14 Day Maximum 100%
Private Duty Nursing	X	$2,500	$5,000	$5,000	$2,500	$5,000	$5,000	$1,500	$2,500	$5,000
Psychologist/ Master of Social Work	X	$300 combined	$400 combined 100%	$500 combined	$300 combined	$400 combined 100%	$500 combined	$400 combined	$500 combined	$500 combined
Speech Therapist	X	$300	$400 100%	$500	$300	$400 100%	$500	$400	$500	$500
Physiotherapist	X	$300	$400	$500	$300	$400	$500	$400	$500	$500
Podiatrist/Chiropodist	X	$300 combined	$400 combined 100%	$500 combined	$300 combined	$400 combined 100%	$500 combined	$400 combined	$500 combined	$500 combined
Massage/Chiropractor/ Osteopath/Naturopath/ Acupuncturist/Dietician/ Occupational Therapist	X	$300 combined	$400 combined	$500 combined	$300 combined	$400 combined	$500 combined	$400 combined	$500 combined	$500 combined
Vision	X	$100 $65 Exam 100%	$150 $65 Exam 100%	$250 Exam Incld. in Total	$100 $65 Exam 100%	$150 $65 Exam 100%	$250 Exam Incld. in Total	$100 Exam **Not** Incld. 100%	$200 Exam Incld. in Total 100%	$250 Exam Incld. in Total 100%
Audio	X	$300	$400 100%	$600	$300	$400 100%	$600	$300	$500	$750
Accidental Dental	X	$1,500	$2,500 100%	$2,500	$1,500	$2,500 100%	$2,500	$1,500	$2,500	$5,000
Medical Items	X	$1,250	$2,500	$5,000	$1,250	$2,500	$5,000	$1,500	$2,500	Unlimited
Emergency Transportation	X	Unlimited	Unlimited 100%	Unlimited	Unlimited	Unlimited 100%	Unlimited	Unlimited 80%	Unlimited	Unlimited
Medical Alert Bracelets	X	$50	$50	$50	$50	$50	$50	$50	$50	$50
Employee Assistance Program	X	Included	Included	Included	Included	Included	Included	Included	Included	Included

* If you qualify for **Plan 1A** or **Plan 1** you have the option to apply for Optional Life Insurance and/or Employee Long Term Disability

† GUARANTEED - 60 day window conditions may apply

Dental Coverage

Dental care coverage is optional coverage which is available as an add-on to any plan

Deductible: There is no deductible.
Co-insurance: Percentage of an eligible claim the insurer pays.
Fee Guide: Coverage follows the current fee guide.
Note: Coverage maximums stated below are per benefit year, unless otherwise specified and apply to each subscriber and insured dependant.

Basic	Enhanced
Year 1: 70% Year 2+: 80%	Year 1: 80% Year 2+: 80%

Overall Coverage Maximums

	Basic	Enhanced
Year 1	$500	$700
Year 2	$750	$850
Year 3	$1000	$1000

Endodontic and Periodontal Services

Basic	Enhanced
50%	80%

Major Restorative Services

(available ONLY after the 36th consecutive month of dental coverage

Basic	Enhanced
Not Included	50%

Summary of Eligible Services

Recall Examinations Once Every 9 Months
Fillings, Cleanings, Scalings, Examinations and Polishing
Extractions
Endodontic Treatment (root canal therapy)
Periodontal Treatment (diseased bones and gums)
Standard Services
General Anesthetic

Major Restorative Services

(ENHANCED Dental Care Only)

Dentures: standard dentures including complete, immediate, transitional and partial dentures.
Crowns: standard onlays or crown restorations (paid to full metal on molar) to restore diseased or accidentally injured natural teeth.
Bridges: standard bridges, including pontics, abutment retainers/ crowns (paid to full metal on molar) on natural teeth
Repair: standard repair or re-cementing of crowns, onlays and bridge work on natural teeth.

Additional, Optional and Excess Coverage

Employees have the opportunity to apply for a variety of additional and excess coverage options. This coverage is medically underwritten and impacts the total monthly premium.

See coverage options below and refer to worksheet request form for optional coverage (form 4)

Optional Additional Life Insurance

- Employee
- Convertible
- Available in units of $10,000
- Available to a maximum of $500,000

Optional Life Insurance

- Spouse and/or Child
- Spouse convertible, child non-convertible
- Spouse: Available in units of $10,000 to a maximum of $500,000
- Child: Available in units of $5,000 to a maximum of $50,000

Long Term Disability Income

- Employee only
- Available in units of $100
- Available up to a total of 65% of your salary to a maximum benefit of $5,000 a month (this maximum includes the $1,000 Basic Coverage which is offered in Plan 1a and Plan 1)

Maximums: There is no lifetime maximum. Annual maximums, where applicable.
CO INSURANCE: Percentage the Insurer pays, subject to coverage maximums, applies to all catagories of coverage unless otherwise specifically stated.
Deductible: There is no deductible.
NOTE: Coverage maximums stated are per benefit year, unless otherwise specified, and apply to each employee and insured dependant. Complete Form 2, included in this enrollment kit, when applying for Optimum Level of Health Care Coverage.

Details:

Prescription Drugs: (Pay Direct Drug Card system) Benefits include drugs legally requiring a prescription, diabetic needles and syringes. Pay generic only unless otherwise indicated in the prescription. Benefits do not include smoking cessation products and medication for the treatment of obesity, erectile dysfunction and infertility.

Out of Country Travel: Emergency medical services up to 60 days for each trip; dollar maximum is per CALENDAR year regardless of the number of trips

Trip Cancellation: Per covered person per trip included in the overall maximum out of country

Hospital Accommodations: Semi private room in a public general hospital

Private Duty Nursing: Services of an R.N or R.P.N or L.P.N

Vision: (maximums apply every 24 months based on date of first paid claim) Prescription eye glasses and/or contact lenses and/or laser eye surgery, Eye exams (applies only to adults ages 20 years - 64 years inclusive)

Audio: Hearing aids, repairs or replacement parts (maximums apply every 5 years based on date of first paid claim)

Accidental Dental: Accidental injury to natural teeth. Submit accident report immediately

Medical Items: Includes items such as wheelchair, hospital bed, glucometer and lancets, orthotics, prosthetics, ventilator, pressure gradient stocking etc. Each individual item is scaled to usual customary limits.

Emergency Transportation: Land or air ambulance

Medical Alert Bracelets: Maximums apply every 2 years based on date of first paid claim

Employee Assistance Program: 3 sessions (telephonic/e-counseling/in-person) per person, per issue

Premium Guide

Premium Guide

Rates Effective November 1st, 2017 for Residents of Ontario

Plan 1

	Extended Health Care Coverage *(No Dental)*	Extended Health Care *including* Basic Dental	Extended Health Care *including* Enhanced Dental
Single	$127.51	$175.04	$191.91
Couple	$225.16	$309.56	$339.80
Family	$267.34	$397.13	$443.22

Employee Life, ADD&D and Long Term Disability are included in Plan 1.

Plan 2

	Extended Health Care Coverage *(No Dental)*	Extended Health Care *including* Basic Dental	Extended Health Care *including* Enhanced Dental
Single	$106.03	$153.56	$170.43
Couple	$203.68	$288.08	$318.32
Family	$245.86	$375.65	$421.74

Plan 1A

Employee Life, Accidental Death, Disease & Dismemberment, Long Term Disability and Employee & Family Assistance Program	$31.99

65+ Essential Level Coverage (no drugs)

	Extended Health Care *(No Dental)*	Extended Health Care *including* Basic Dental	Extended Health Care *including* Enhanced Dental
Single	$66.15	$118.18	$139.97
Couple	$130.36	$223.90	$261.70
Family	$140.61	$285.38	$342.43

65+ Complete and Optimum Level Coverage (with drugs)

	Extended Health Care *(No Dental)*	Extended Health Care *including* Basic Dental	Extended Health Care *including* Enhanced Dental
Single	$120.61	$172.64	$194.43
Couple	$235.52	$329.06	$366.86
Family	$269.09	$413.86	$470.91

All rates listed are paid ***monthly*** and are inculsive of all taxes.

Your coverage and your premium may be affected by changes in your weekly hours of work, your job status and/or your family status. It is your sole responsibility to make Health Care Providers aware of any such changes at the time of occurrence. Any premium paid towards coverage for which you were ineligible or which you no longer required as a result of non-contact at the time of the changes will not be refunded.

Please visit

www.healthcareproviders.ca

to learn more about making premium payments

60 DAY OFFER FORM

New Part Time & Casual hire?
Full Time transferring to Part Time or Casual?
Full Time retiring from the hospital?
Full Time permanently laid off from hospital?
Full Time losing Hospital Benefits at age 65?

To confirm your eligibility for guaranteed COMPLETE LEVEL coverage you must submit one of the following with your application:

A. copy of your hospital offer letter or other official document outlining your offer of employment, retirement, or layoff, and in particular indicating the start date of the occurrence

OR

B. this form completed by an authorized Human Resources professional at your hospital

TO BE COMPLETED BY HUMAN RESOURCES PERSONNEL ONLY

NEW EMPLOYEE / FULL TIME TRANSFER TO: **PART TIME** ☐ **CASUAL** ☐ **TEMPORARY** ☐ **CONTRACT** ☐

I certify that ____________________ (first name, last name) started his/her current employment at

____________________ (Hospital name) on ____________________ (dd/mm/yyyy)

- -

FULL TIME EMPLOYEE: **RETIRING** ☐ **PERMANENTLY LAID OFF** ☐ **LOSING BENEFITS AGE 65** ☐

I certify that ____________________ (First name, Last name) is retiring, being permanently laid off, or losing their Full Time Benefits at age 65 on ____________________ (dd/mm/yyyy) after having been actively employed immediately prior to this occurrence at ____________________ (Hospital)

- -

____
Name of Authorized Human Resources Staff Member (Please print)

____
Signature of Authorized Human Resources Staff Member

HEALTH CARE PROVIDERS GROUP ENROLLMENT FORM

TO PROCESS YOUR APPLICATION ALL APPLICABLE FIELDS ON THIS FORM MUST BE COMPLETED.

CHOOSE YOUR COVERAGE:

If you are applying for couple or family coverage and one applicant is over age 65 and the other(s) is not, simply tick the applicable boxes in both columns to indicate your coverage selection in both plans.

Select a Plan	Plan 1A ☐	Plan 1 ☐	Plan 2 ☐	Plan 65+ ☐
Select Dental Coverage	No Dental ☐	Basic Dental ☐	Enhanced Dental ☐	

Plan 1 & 2 ONLY: ☐ I do not wish to apply for coverage other than what I am guaranteed
Plan 65+ ONLY: ☐ I wish to apply for the essential level of coverage regardless of my guarantee

LAST NAME: _____ **FIRST NAME** _____ **MIDDLE INITIAL**___

_____/_____/_____/_____
ADDRESS CITY PROVINCE POSTAL CODE

HOME TELEPHONE: (____)_____ **EMAIL ADDRESS:** _____

MALE ☐ **FEMALE** ☐ **DATE OF BIRTH**: (DD/MM/YYYY) _____/_____/_____

SINGLE ☐ **MARRIED** ☐ **COMMON LAW** (SEE DECLARATION OVERPAGE) ☐ **SEPARATED** ☐ **DIVORCED** ☐ **WIDOWED** ☐

DEPENDENTS ENROLLMENT INFORMATION

ANY DEPENDENTS (Incl. spouse) ELIGIBLE FOR COVERAGE UNDER THIS PLAN MUST BE LISTED BELOW

Dependents	Surname	First Name	M/F	DOB (dd/mm/yyyy)	Full Time Student (Y/N) (age 21-25)
Spouse					
1st Child					
2nd Child					
3rd Child					
4th Child					

FOR EMPLOYEES ONLY (CURRENT POSITION)

PART TIME ☐ **CASUAL** ☐ **TEMPORARY** ☐ **CONTRACT** ☐

Date hired: (dd/mm/yyyy) _____/_____/_____

Are you currently on maternity, disability or any other kind of leave?
YES ☐ **NO** ☐

Average weekly hours: _____ Gross monthly salary: $_____

Occupation:_____

Hospital: _____

Hospital Tel: _____ Ext. _____

FOR RETIREES ONLY

RETIRED FROM HOSPITAL ☐

Date Retired :(dd/mm/yyyy) _____/_____/_____

Last date actively work at hospital: (dd/mm/yyyy)
_____/_____/_____

Have you retired while on Disability or other kind of leave?
YES ☐ NO ☐

Are you currently collecting **ANY** Long Term Disability benefits?
YES ☐ NO ☐

Hospital: _____

PLAN 1A ONLY Are you currently covered under your spouse's (or another group's) benefit plan?

PROVIDED BY: _____ **INSURED THROUGH:**_____
Name of employer or other provider Name of Insurance Company

PLAN 1 and PLAN 1A ONLY: Beneficiary Designation

BENEFICIARY: _____ **RELATIONSHIP TO INSURED:** _____

TRUSTEE : _____
(Name a Trustee if beneficiary is under age 18. Will expire when beneficiary reaches age 18)

***APPLICATION FOR COMMON-LAW COVERAGE – DECLARATION**

I the undersigned, hereby certify that I have been living with _____ since (dd/mm/yyyy) ____/_____/_____ and representing him/her as my spouse or my (common-law) spouse. I further certify that I and/or my (common-law) spouse are solely responsible financially for either of our children claimed for insurance purposes. I further certify that I do not have or I do not wish to provide coverage to my legal spouse, if any.

MANDATORY INFORMATION FOR ALL ENROLLMENTS

REQUEST FOR PRE-AUTHORIZED PAYMENT PLAN ***your account must have chequing privileges***

I hereby authorize Health Care Providers to arrange automatic deductions from the following account:

Your name as shown on the account:

_____

Name of your Bank:

_____

Address of Bank: _____ City: _____ Postal Code:_____

Date: _____ Signature: **X**_____
(dd/mm/yyy)

*Two (2) cheques are required with your application; please make them both payable to **HCP Group Insurance.** Also please ensure that these two (2) cheques are drawn on the account from which you wish us to withdraw your monthly premium.*

☐ ***I am applying for Plan 65+. I request that my withdrawal dates be on the first day of the month.***

ENROLLMENT ACKNOWLEDGEMENT:

I hereby enroll for the benefit coverage from the Health Care Providers Group Insurance Plan™ for which I am eligible, and I authorize the hospital to release address, phone, and income information to the Plan Administrator if required. I acknowledge all information is complete and accurate. I understand that I and my dependents must be covered under a Provincial Health Plan and that I (retirees excluded) must be actively working in order to be eligible for coverage. I understand that the Health evidence provided by me and my dependents as part of this enrollment may be used by all parties involved in the issuing of my coverage and I hereby consent to such usage on behalf of myself and any dependents for whom coverage is sought. I understand that Health Care Providers Group Insurance Plan™ reserves the right to audit claims.

I understand coverage is effective on the first of the month following the date my enrollment is received, unless I elect to delay the effective date one month provided all of the following requirements have been met:

- A fully completed signed enrollment and required premium has been received
- Underwriting approval (when underwriting is required)
- I continue to meet all eligibility rules.

It is my sole responsibility to inform Health Care Providers of any changes in my work hours, status or otherwise in the event that it may affect eligibility for coverage and failure to do so may result in premiums paid when coverage is not required and refunds under these circumstances will not be made.

Date _____ **Signature of Employee: X** _____

PRIVACY: All information about the insurability of you and your dependents is considered confidential. HCP is a business name registered to Hardiman Mount & Associates Insurance Brokers Limited and we are committed to protecting the privacy, confidentiality, accuracy and security of the personal information that is collected, used, retained and disclosed in the course of conducting business.

HEALTH CARE PROVIDERS GROUP INSURANCE PLAN™
STATEMENT OF HEALTH

2

(Please answer ALL questions)

Employee information only

Last Name _____ First Name _____ Hospital _____ Dept _____

Information about you and your dependents

1. List all persons eligible for coverage including yourself spouse, and all eligible dependents)

Relationship to Employee	Name	Birthdate dd/mm/yyyy	Height feet/inches	Weight pounds	Smoker (Y/N)
Myself - Employee					
Dependent Spouse					
Dependent Child #1					
Dependent Child #2					
Dependent Child #3					
Dependent Child #4					
Dependent Child #5					

2. Have you or any of your dependents ever consulted a physician or alternative health care provider (including herbalist, acupuncturist, massage therapist, chiropractor, or practitioner of homeopathy or naturopathy, etc) about, been treated for, or had any known indication of any of the following:
(If "Yes", please circle which and give details in 6, over page).

		Yes	No			Yes	No
(a)	Circulatory or Heart or Vascular disease, High Blood Pressure, Angina, Stroke or TIA (mini stroke), Elevated cholesterol, Chest Pain or Heart Murmur?	☐	☐	(i)	Immune Disorder including testing for Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Syndrome (HIV)?	☐	☐
(b)	Arthritis, Gout, Rheumatism, Osteoporosis/Osteopenia, disorder of joints or limbs or spine, joint or muscle pain?	☐	☐	(j)	Skin Disorder including Acne, Rosacea, Psoriasis or Eczema?	☐	☐
(c)	Colitis, Crohn's, Irritable Bowel Syndrome, Ulcers, Hernia, Reflux or persistent Heart Burn?	☐	☐	(k)	Infertility, Reproductive disorder, Menopause, Disorder of Breasts, Ovaries, Cervix or Uterus?	☐	☐
(d)	Stomach, Intestinal, Kidney, Bladder or Liver Disorder including Hepatitis?	☐	☐	(l)	Headaches/migraines, Dizziness, Fainting, Disorder of the brain or nervous system?	☐	☐
(e)	Mental, Anxiety, Emotional Disorder, Depression, Alzheimer's, Dementia, Parkinson's, Seizures or Paralysis?	☐	☐	(m)	Sexually Transmitted Disease or infection (STD's or STI's) or recurring infections (including Cold Sores/Herpes)?	☐	☐
(f)	Alcohol or drug dependency?	☐	☐	(n)	Diabetes or Endocrine disorder?	☐	☐
(g)	Lung Condition, Respiratory Condition including COPD, Asthma or Allergies, Sleep Apnea?	☐	☐	(o)	Disorder of the eyes, ears, nose or throat?	☐	☐
(h)	Cancer, Tumor or any other growth?	☐	☐	(p)	Anemia or low iron?	☐	☐

3.	Have you or any of your dependents ever been treated or hospitalized for or had any known indication of any Physical Impairment, Condition, Disease or Disorder not stated above? If "Yes", please give details in 6 over page.	☐	☐
4.	Are you or any of your dependents currently taking prescription or non-prescription medications of any kind or been advised by a physician or Alternative Health Care Provider to take medication of any kind? If "Yes", please give details in 6 over page.	☐	☐
5.	Have you or any of your dependents ever been advised to have an investigation, hospitalization or surgery which has not yet been completed? If "Yes", please give details in 6 over page.	☐	☐

HEALTH CARE PROVIDERS GROUP INSURANCE PLAN™
STATEMENT OF HEALTH (CONT.)
(Please answer ALL questions)

6.

Question Number (previous page)	Employee or Dependent's Name	Nature of Illness	Date of Onset and Recovery dd/mm/yyyy	Type of Medication and/or Treatment	Approx. Monthly Cost of Medication	How often do you see your Doctor for treatment?

NOTE: Based on your medical history or that of a dependent, coverage may be declined or modified to exclude certain prescription drugs. Coverage that is approved will commence no earlier than the first of the month following final approval of the application of which this statement of health is part.

Employee's Declaration

I hereby declare that all the statements contained in this application for the Health Care Providers Group Insurance Plan™ are true and complete and together with any other forms signed by me in connection with this application, form the basis for any agreement issued thereunder. I hereby authorize any licensed physician, medical practitioner, hospital, clinic, medical facility or organization which has records of my or my dependents health to release such information to the Plan Administrator. I understand and agree that information related to the administration of benefits may be provided to third parties to whom access has been granted or those authorized by law. A photocopy of this signed authorization shall be as valid as the original. I understand and agree that any injury that occurred on or before the date of this application or any medical condition, the signs of which first appeared on or before the date of this application may not be covered by the agreement. I understand it is my obligation to inform HCP of a change in my health or that of my spouse or any listed dependent children due to either injury or illness which occurs after the date of application and prior to the date of approval. Failure to disclose such information could result in denial of a claim and the cancellation or modification of this agreement. Health Care Providers Group Insurance Plan™ reserves the right to recover any claims paid due to the applicant's failure to disclose an injury or medical condition that existed on or before the date of this application. I understand that Health Care Providers Group Insurance Plan™ reserves the right to audit claims.
NOTE: This form is valid for ONLY 60 days from the date it is signed!

Dated at _____ this _____ day of _____ 20 _____
(City/Town)

Employee's Signature: **X** _____

Privacy Statement

All information about the insurability of you and your dependents is considered confidential. HCP is a business name registered to Hardiman Mount & Associates Insurance Brokers Limited. We are committed to protecting the privacy, confidentiality, accuracy and security of the personal information that is collected, used, retained and disclosed in the course of conducting business.

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HEALTH CARE PROVIDERS GROUP INSURANCE PLAN PLAN MEMBER GROUP HEALTH FORM

Group Health form to be used when Plan Member is applying for:
- Basic Life, AD&D, & Disability
- Optional Group Life Insurance
- Optional Long Term Disability

3

To avoid delays, please complete the required information by printing clearly in ink. All questions must be answered or form will be returned.

PLAN MEMBER INFORMATION (To be completed by the Plan Member)

Group 6414 Account 1 Certificate _____ Group Name _____

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

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

Phone Number: Home (_____) _____ Work (_____) _____ Cell (_____) _____

Date of Birth _____ (MMM/DD/YYYY) ☐ Male ☐ Female Height _____ Weight _____

Occupation _____ Are you actively at work? ☐ Yes ☐ No If no, why? _____

IF APPLYING FOR ADDITIONAL EMPLOYEE GROUP LIFE COVERAGE, PLEASE COMPLETE THE FOLLOWING SECTION:

Amount of Additional Employee Group Life Insurance being applied for $ _____ (coverage is available in Units of $10,000 to a maximum of $500,000)

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

HEALTH EVIDENCE

1. Have any family members been diagnosed with diabetes, heart disease, high blood pressure, elevated blood fats, cancer, mental illness, HIV, or had a stroke?	☐ Yes ☐ No	If yes, specify:
2. Have any of your parents, brothers or sisters had any hereditary disorder (i.e.: Huntington's chorea, polycystic kidney disease, etc.)?	☐ Yes ☐ No	If yes, specify:
3. Have you ever consulted a physician or Alternative Health Care Provider (including herbalist, acupuncturist, chiropractor or practitioner of homeopathy or naturopathy, etc.) for, or ever had any condition of (please specify which):		**Details of "Yes" answers** Identify question number, circle applicable items. Include date, diagnosis, duration, type and amount of treatment (list name of drug, strength and dosage, if applicable), outcome/result, as well as name and address of doctor consulted.
a) Disorder of eyes, ears, nose or throat?	☐ Yes ☐ No	
b) Severe headaches, dizziness, fainting, loss of consciousness, epilepsy, seizures, speech disorders, paralysis, stroke, disorder of brain or nervous system?	☐ Yes ☐ No	
c) Nervous disorders, including depression, severe anxiety or suicidal thoughts?	☐ Yes ☐ No	
d) High blood pressure, palpitation or pain about the heart or chest, difficult breathing, cardiac disorders, angina or coronary disease, rheumatic fever, heart murmur, heart attack or other disorder of heart or blood vessels?	☐ Yes ☐ No	
e) Persistent cough or hoarseness, coughing of blood, asthma, emphysema, pleurisy, bronchitis, tuberculosis, respiratory disease or other disorder of the lungs?	☐ Yes ☐ No	
f) Ulcer of stomach or duodenum, recurrent indigestion, jaundice, gall stones, colitis, bleeding or chronic diarrhea, disorders of stomach, gall bladder, liver, intestines, pancreas, rectum, or digestive system?	☐ Yes ☐ No	
g) Hepatitis A, B, C, or "type unknown"?	☐ Yes ☐ No	
h) Albumin, sugar, pus or blood in urine, diabetes, kidney stone or colic, or any other disorder of kidney or bladder?	☐ Yes ☐ No	
i) Arthritis, gout, rheumatism, sciatica, deformity or disorder of joints or limbs, any disorder of the muscles or spine, including degenerative disc disease, pain in neck or back, trauma to spine, use of brace or cervical collar, fibromyalgia or chronic fatigue syndrome?	☐ Yes ☐ No	
j) Leukemia, anemia, hemophilia or any other disorder/abnormality of the blood?	☐ Yes ☐ No	
k) Cancer, tumours, enlarged glands (nodes) or skin lesions, abnormal cysts or growths, pituitary, adrenals or other glands or unexplained infections?	☐ Yes ☐ No	
l) Thyroid or other endocrine disorders?	☐ Yes ☐ No	
m) Venereal disease or any sexually transmitted disease or disorder of prostate or reproductive organs?	☐ Yes ☐ No	
n) Other than previously listed, have you had any other conditions, illnesses, ailments, diseases, injuries, operations, visited any other doctor or had any diagnostic tests?	☐ Yes ☐ No	
4. In the past 10 years have you:		
a) Had or been told you had Acquired Immune Deficiency Syndrome (AIDS), "AIDS" Related Complex (ARC), or "AIDS" related conditions?	☐ Yes ☐ No	
b) Received advice or treatment in connection with any of the categories mentioned in (4a)?	☐ Yes ☐ No	
c) Tested positive for antibodies to AIDS (Human T-cell Lymphotropic, TYPE III); HTLV-III virus?	☐ Yes ☐ No	
5. Has an application for insurance on your life/health ever been declined, rated or modified in any way?	☐ Yes ☐ No	When? _____ Why? _____ Company? _____

HEALTH EVIDENCE (CONTINUED) To be completed by the Plan Member

6. Do you currently have an individual life policy with The Co-operators that has been issued within the last five years?	☐ Yes ☐ No	If yes, Policy # _____
7. Have you applied for or received a pension or Workers' Compensation or disability benefits because of illness or injury?	☐ Yes ☐ No	When? _____ Why? _____
8. Have you lost any time from work during the last 12 months because of illness or injury?	☐ Yes ☐ No	When? _____ Amount of time? _____ Why? _____
9. Do you have any condition for which hospitalization or surgery has been advised or is contemplated? If yes, give details and dates.	☐ Yes ☐ No	
10. Are you receiving any treatment/medication from any physician or alternative healthcare provider as previously not defined? If yes, state type and frequency.	☐ Yes ☐ No	
11. Female Applicant a) Have you ever had any disease of the breasts, ovaries, cervix or uterus? b) Have any pregnancies or labours been abnormal?	☐ Yes ☐ No ☐ Yes ☐ No	If yes, circle applicable items. Include date, diagnosis, duration, type and amount of treatment (list name of drug, strength and dosage, if applicable), outcome/result, as well as name and address of doctor consulted.
c) Are you pregnant?	☐ Yes ☐ No	If yes, give expected delivery date: _____
12. Do you now or have you ever used alcohol?	☐ Yes ☐ No	If Yes, complete the following: Frequency of use: ☐ Daily ☐ Weekly ☐ Monthly Amount consumed on each occasion: _____ Date last used: _____
13. Have you ever received or been advised to obtain any treatment for alcohol/drug use (including AA membership)?	☐ Yes ☐ No	If yes, give details and dates: _____
14. Do you now or have you ever used non-prescription drugs, hallucinogenic, stimulant, narcotic, sedative or tranquilizing drugs (including marijuana or cocaine)?	☐ Yes ☐ No	If Yes, complete the following: Type of drug: _____ Frequency of use: ☐ Daily ☐ Weekly ☐ Monthly Date last used: _____
15. Have you ever used any form of tobacco, marijuana, nicotine products or substitutes (including nicotine patch and gum)?	☐ Yes ☐ No	If yes, for how long and how many per day? _____

16. Who is your regular family physician?(If none, Walk In Clinic visited) _____

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

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

PRIVACY STATEMENT

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.

PLAN MEMBER DECLARATION AND AUTHORIZATION

I have read and understood the privacy statement and I consent to the collection, use, retention and disclosure of my personal information or those of my dependents for the purpose stated above. I understand that I may revoke my consent at any time in writing and acknowledge that should I do so, my claim may not be adjudicated.

I authorize any person or organization who maintains my personal and health records or information to provide The 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 The Co-operators to release my personal and health information to my physician, the Public Health authorities, and The 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.

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 The 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 The Co-operators voiding my insurance coverage.

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

This form must be received in our office within 60 days of the above date. Otherwise, a new form must be submitted.

Worksheet Request Form for Optional Life Insurance and/or Optional Employee Long Term Disability Income (only applies to Plan 1)

Please fill out this worksheet and submit with your application and appropriate Health forms when applying for any optional benefit coverage under Plan 1. (see over for monthly unit rates)

Name:_____ Hospital: _____

Home Phone Number: (_____)_____ Gross Monthly Salary: _____

Smoker(Y/N)_____ Male/Female(M/F)_____ Date of Birth (dd/mm/yyyy) /____/_____/_____

Optional Life Insurance for employee and spouse can be purchased in units of $10,000 to a maximum of $500,000. Optional child insurance can be purchased in units of $5,000 up to a maximum of $50,000

PLEASE COMPLETE

(example below - unit rates see over page)

Optional Life Insurance

Name	Unit Rate (see over)	# of Units	Monthly Premium
Employee_____	____	_____	$_____
Spouse _____	____	_____	$_____
Child 1 _____	____	_____	$_____
Child 2 _____	____	_____	$_____
			$_____ (A)

Optional Employee Long Term Disability

Name	Unit Rate (see over)	# of Units	
Employee_____	____	_____	**$_____ (B)**

Total (A+B)	**$_____**
Tax (8%)	**$ _____**
Total	**$_____**

Example

Optional Life Insurance

Name	Unit Rate	# of Units	Monthly Premium
Employee (F 42 NS)	1.10 x	10 units ($10,000 each)	$11.00
Spouse (M 45 NS)	2.50 x	5 Units ($10,000 each)	$12.50
Child 1	0.70 x	2 Units ($5,000 each)	$ 1.40
			$24.90 (A)

Optional Employee Long Term Disability

Name	Unit Rate	# of Units	
Employee (F 42)	2.90 x	5 units ($100 each)	**$14.50 (B)**
		Sub Total (A+B)	**$39.40**
		Tax (8%)	**$ 3.15**
		***Total**	**$42.55**

Health Care Providers Group Insurance Plan™

RATE PAGE
Monthly Unit Rates for Optional Insurance and Employee Long Term Disability Income

Unit rates are reviewed annually on November 1st, and are subject to change. Last rate change November 2004

Evidence of Good Health is required for all optional Benefit Coverage – health forms in your enrollment package

Optional Life Insurance (Employee - Form 3 and Spouse - Form 5)

- Monthly rates per unit of $10,000

	Smoker		Non-Smoker	
Age	**Male**	**Female**	**Male**	**Female**
Under age 30	1.20	1.00	1.00	.80
30-39	1.80	1.50	1.20	1.00
40-44	3.00	2.00	1.40	1.10
45-49	5.50	3.80	2.50	1.80
50-54	8.80	5.80	4.50	2.80
55-59	13.30	8.20	6.40	4.00
60-64	18.00	11.40	9.90	7.00

Optional Child Life Insurance (Form 6)

- Monthly rate per unit of $5,000 is $ 0.70

Optional Employee Long Term Disability Income (Form 3)

- Monthly rates per unit of $100.00 of Optional Employee Long Term Disability Income

Age	
Under age 35	1.19
35-39	2.16
40-44	2.90
45-49	4.03
50-54	5.45
55-59	6.68
60-64	6.56

Optional employee long term disability can be purchased for up to 65% of your salary to a maximum benefit of $5,000 (ie: $4,000 in addition to the $1,000 base benefit you have under Plan 1)

IMPORTANT

When applying for the above optional coverage please note

1. **Complete the Worksheet on the other side of this page and submit all applicable forms with your application**
2. **DO NOT INCLUDE the monthly premium that you calculate for your optional coverage with your application. This additional monthly amount will be withdrawn automatically from your bank account once approval has been given**

Health Care Providers Group Insurance Plan™

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OPTIONAL GROUP LIFE INSURANCE APPLICATION FOR SPOUSE HEALTH CARE PROVIDERS GROUP INSURANCE PLAN

5

To avoid delays, please complete the required information by printing clearly in ink.
This form must be received in our office within 60 days of the application being signed, otherwise a new application must be completed.

PLAN MEMBER INFORMATION

Group 6414 Account 1 Certificate _____ Group Name _____

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

Is Plan Member actively at work? ☐ Yes ☐ No If no, why? _____

APPLICANT INFORMATION

Applicant: ☐ Spouse _____ (First Name) _____ (Initial) _____ (Last Name)

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

Phone Number: Home (_____)_____ Work (_____)_____ Cell (_____)_____

Date of Birth _____ (MMM/DD/YYYY) ☐ Male ☐ Female Height _____ Weight _____

Annual Salary $ _____ Occupation _____

COVERAGE AMOUNT (coverage is available in units of $10,000 to a maximum of $500,000)

Existing Optional Group Life Amount: $_____ (under this group)

New Total Amount Requested: $ _____

BENEFICIARY INFORMATION (designation by plan member only)

Beneficiary in the event of death of the Applicant

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

For Spousal Applications the beneficiary of this insurance will be the employee.
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

APPLICANT DECLARATION OF INSURABILITY

1. Have any family members been diagnosed with diabetes, heart disease, high blood pressure, elevated blood fats, cancer, mental illness, HIV, or had a stroke? ☐ Yes ☐ No
   If yes, specify _____

2. Have any of your parents, brothers or sisters had any hereditary disorders? ☐ Yes ☐ No
   If yes, specify (ie: Huntington's chorea, polycystic kidney disease, etc.) _____

3. Have you had any symptoms of, or treatment for, any medical condition, disorder or ailment that resulted in your hospitalization within the last 2 years? ☐ Yes ☐ No
   If yes, give details below:

Name of Disorder	Date of Onset (MMM/DD/YYYY)	Date of Recovery (MMM/DD/YYYY)	Attending Physician or Hospital	Result

4. Are you now, to the best of your knowledge and belief, in good health and free from all symptoms of illness and disease? ☐ Yes ☐ No
   If no, give details below:

Name of Disorder	Date of Onset (MMM/DD/YYYY)	Attending Physician or Hospital	Result

5. Are you now under observation or taking treatment or medication from any physician or alternative health care provider for any disorder, ailment or condition? (Alternative health care provider includes herbalist, acupuncturist, chiropractor or practitioner of homeopathy or naturopathy, etc.) ☐ Yes ☐ No
   If yes, what? _____ Why? _____

6. Who is your regular physician or family doctor? _____ If none, walk-in clinic visited:
   _____ (Street) _____ (City) _____ (Province) _____ (Postal Code)
   Approximate Date Last Seen _____ (MMM/DD/YYYY) Reason and Result _____

7. Do you have any condition for which hospitalization or surgery has been advised or is contemplated? ☐ Yes ☐ No
   If yes, give details _____

APPLICANT DECLARATION OF INSURABILITY (CONTINUED)

8. Have you ever had or been told you had any of the following:
   a) Lung or respiratory disorder (e.g. asthma, bronchitis, tuberculosis, emphysema)? ☐ Yes ☐ No
   b) Heart trouble (e.g. pain in the chest, shortness of breath, high blood pressure, rheumatic fever, murmur, heart attack or stroke)? ☐ Yes ☐ No
   c) Stomach trouble (e.g. ulcer, appendicitis, gall bladder, hernia, or other digestive disorder, colitis)? ☐ Yes ☐ No
   d) Diabetes, kidney disease, sexually transmitted disease, or abnormality of the urine? ☐ Yes ☐ No
   e) Cancer, cyst, tumour, growth or blood disorder? ☐ Yes ☐ No
   f) Epilepsy, paralysis, dizziness or brain disorder? ☐ Yes ☐ No
   g) Neuritis, arthritis, rheumatism, back, spine, bone, joint, or muscle disorder? ☐ Yes ☐ No
   h) Nervous or mental disorders, including depression, severe anxiety or suicidal thoughts? ☐ Yes ☐ No
   i) AIDS or an AIDS related complex, or had a positive reaction to a test designed to reveal the presence of Human Immunodeficiency Virus (HIV), or any other immunological disorder? ☐ Yes ☐ No
   j) Hepatitis A,B, C or type unknown, or any other disorder of the liver? ☐ Yes ☐ No
   k) Any disease, impairment or deformity not named above? ☐ Yes ☐ No

   If yes to any question in number 8, give details below:

Name of Disorder	Date of Onset	Date of Recovery	Attending Physician or Hospital	Result
	MMM/DD/YYYY	MMM/DD/YYYY		
	MMM/DD/YYYY	MMM/DD/YYYY		

9. Have you ever taken drugs, including marijuana and cocaine for other than medical purposes or been advised to reduce alcohol consumption or received or have been counselled to receive treatment for drug addiction or alcoholism? ☐ Yes ☐ No

   If yes, give details including: frequency of use: ☐ Daily ☐ Weekly ☐ Monthly ☐ Other _____

   Amount consumed on each occasion _____ Date last used _____ MMM/DD/YYYY

10. Have you ever been refused life insurance or offered insurance modified in any way? ☐ Yes ☐ No

    If yes, date _____ MMM/DD/YYYY Reason _____

11. Tobacco Use: Have you smoked any tobacco products within the past 12 months? (tobacco products include: cigarettes, cigarillos, mini cigars, pipe smoking, chewing tobacco, nicotine gum or patch, marijuana or hashish.) ☐ Yes ☐ No

    If yes, for how long? _____ how many/day? _____

PRIVACY STATEMENT

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.

APPLICANT DECLARATION AND AUTHORIZATION

I have read and understood the privacy statement and I consent to the collection, use, retention and disclosure of my personal information or those of my dependents for the purpose stated above. I understand that I may revoke my consent at any time in writing and acknowledge that should I do so, my claim may not be adjudicated.

I authorize any person or organization who maintains my personal and health records or information to provide The 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 The Co-operators to release my personal and health information to my physician, the Public Health authorities, and The 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.

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 The 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 The Co-operators voiding my insurance coverage.

Signature _____ (Spouse Signature) Date _____ MMM/DD/YYYY

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

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OPTIONAL GROUP LIFE INSURANCE APPLICATION FOR CHILDREN HEALTH CARE PROVIDERS GROUP INSURANCE PLAN

6

To avoid delays, please complete the required information by printing clearly in ink.
This form must be received in our office within 60 days of the application being signed, otherwise a new application must be completed.

PLAN MEMBER INFORMATION

Group ____ **6414** ____ Account ___ **1** ___ Certificate _____ Group Name _____

Plan Member _____ _____ _____
First Name Initial Last Name

Is plan member actively at work? ☐ Yes ☐ No If no, why? _____

APPLICANT INFORMATION

Applicant: ☐ Child _____ _____ _____
First Name Initial Last Name

Mailing Address _____ _____ _____ _____
Street City Province Postal Code

Phone Number: Home (_____)_____ Work (_____)_____ Cell (_____)_____

Date of Birth _____ ☐ Male ☐ Female
MMM/DD/YYYY

COVERAGE AMOUNT (coverage is available in units of $5,000 to a maximum of $50,000)

Existing Optional Group Life Amount: $ _____ (under this group)

New Total Amount Requested: $ _____

BENEFICIARY INFORMATION (designation by plan member only)

Beneficiary in the event of death of the Applicant

_____ _____ _____ Relationship _____
First Name Initial Last Name

For Child Applications the beneficiary of this insurance will be the employee.

APPLICANT DECLARATION OF INSURABILITY

1. Have any family members been diagnosed with diabetes, heart disease, high blood pressure, elevated blood fats, cancer, mental illness, HIV, or had a stroke? ☐ Yes ☐ No
   If yes, specify _____
2. Have any of your parents, brothers or sisters had any hereditary disorders? ☐ Yes ☐ No
   If yes, specify (e.g. Huntington's chorea, polycystic kidney disease, etc.) _____
3. Have you had any symptoms of, or treatment for, any medical condition, disorder or ailment that resulted in your hospitalization within the last 2 years? ☐ Yes ☐ No
   If yes, give details below:

Name of Disorder	Date of Onset	Date of Recovery	Attending Physician or Hospital	Result
	MMM/DD/YYYY	MMM/DD/YYYY		
	MMM/DD/YYYY	MMM/DD/YYYY		

4. Height _____ Weight _____ Has your weight changed in the past year? ☐ Yes ☐ No
   If yes, how much? _____ Why? _____
5. Are you now, to the best of your knowledge and belief, in good health and free from all symptoms of illness and disease? ☐ Yes ☐ No
   If no, give details below:

Name of Disorder	Date of Onset	Attending Physician or Hospital	Result
	MMM/DD/YYYY		
	MMM/DD/YYYY		

6. Are you now under observation or taking treatment or medication from any physician or alternative health care provider for any disorder, ailment or condition? (Alternative health care provider includes herbalist, acupuncturist, chiropractor or practitioner of homeopathy or naturopathy, etc.) ☐ Yes ☐ No
   If yes, what? _____ Why? _____
7. Who is your regular physician or family doctor? _____ If none, walk-in clinic visited:
   _____ _____ _____ _____
   Street City Province Postal Code
   Approximate Date Last Seen _____ Reason and Result _____
   MMM/DD/YYYY
8. Do you have any condition for which hospitalization or surgery has been advised or is contemplated? ☐ Yes ☐ No
   If yes, give details _____

CO-OPERATORS LIFE INSURANCE COMPANY ATTN: GROUP MEDICAL UNDERWRITING DEPARTMENT
1920 COLLEGE AVENUE REGINA SK S4P 1C4 FAX: (306) 347-6180 TOLL-FREE FAX: 1-866-889-9924

APPLICANT DECLARATION OF INSURABILITY (CONTINUED)

9. Have you ever had or been told you had any of the following:
   a) Lung or respiratory disorder (e.g. asthma, bronchitis, tuberculosis, emphysema)? ☐ Yes ☐ No
   b) Heart trouble (e.g. pain in the chest, shortness of breath, high blood pressure, rheumatic fever, murmur, heart attack or stroke)? ☐ Yes ☐ No
   c) Stomach trouble (e.g. ulcer, appendicitis, gall bladder, hernia, or other digestive disorder, colitis)? ☐ Yes ☐ No
   d) Diabetes, kidney disease, sexually transmitted disease, or abnormality of the urine? ☐ Yes ☐ No
   e) Cancer, cyst, tumour, growth or blood disorder? ☐ Yes ☐ No
   f) Epilepsy, paralysis, dizziness or brain disorder? ☐ Yes ☐ No
   g) Neuritis, arthritis, rheumatism, back, spine, bone, joint, or muscle disorder? ☐ Yes ☐ No
   h) Nervous or mental disorders, including depression, severe anxiety or suicidal thoughts? ☐ Yes ☐ No
   i) AIDS or an AIDS related complex, or had a positive reaction to a test designed to reveal the presence of Human Immunodeficiency Virus (HIV), or any other immunological disorder? ☐ Yes ☐ No
   j) Hepatitis A,B, C or type unknown, or any other disorder of the liver? ☐ Yes ☐ No
   k) Any disease, impairment or deformity not named above? ☐ Yes ☐ No

   If yes to any question in number 9, give details below:

Name of Disorder	Date of Onset	Date of Recovery	Attending Physician or Hospital	Result
	MMM/DD/YYYY	MMM/DD/YYYY		
	MMM/DD/YYYY	MMM/DD/YYYY		

10. Have you ever taken drugs, including marijuana and cocaine for other than medical purposes or been advised to reduce alcohol consumption or received or have been counselled to receive treatment for drug addiction or alcoholism? ☐ Yes ☐ No

    If yes, give details including: frequency of use: ☐ Daily ☐ Weekly ☐ Monthly ☐ Other _____

    Amount consumed on each occasion _____ Date last used _____ MMM/DD/YYYY

11. Have you ever been refused life insurance or offered insurance modified in any way? ☐ Yes ☐ No

    If yes, date _____ MMM/DD/YYYY Reason _____

12. Tobacco Use: Have you smoked any tobacco products within the past 12 months? (tobacco products include: cigarettes, cigarillos, mini cigars, pipe smoking, chewing tobacco, nicotine gum or patch, marijuana or hashish.) ☐ Yes ☐ No

    If yes, for how long? _____ how many per day? _____

PRIVACY AND DECLARATION

PRIVACY STATEMENT 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.

APPLICANT DECLARATION AND AUTHORIZATION

The applicant includes the Parent or Guardian of a child under 16 years of age to be insured.

I have read and understood the privacy statement and I consent to the collection, use, retention and disclosure of my personal information or those of my dependents for the purpose stated above. I understand that I may revoke my consent at any time in writing and acknowledge that should I do so, my claim may not be adjudicated.

I authorize any person or organization who maintains my personal and health records or information to provide The 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 The Co-operators to release my personal and health information to my physician, the Public Health authorities, and The 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.

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 The 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 The Co-operators voiding my insurance coverage.

Signature _____ (Child Signature, if age 16 or over) Date _____ MMM/DD/YYYY

Signature _____ (Plan Member Signature, application for child under age 16 years) Date _____ MMM/DD/YYYY