

Optional Accidental Death And Dismemberment Insurance Application

OPTIONAL ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE APPLICATION

Accidents happen everywhere -- on the job, at home, on holidays and in many situations. This insurance provides an opportunity to purchase economical supplemental Accidental Death and Dismemberment Insurance.

How Does It Work?

Coverage is available in units of \$10,000 to the maximum specified in the policy.

As an example, an individual wishes to purchase 5 units (5 x \$10,000 - \$50,000) of Optional Accidental Death and Dismemberment coverage.

If you choose the Family Plan:

- your spouse will be insured for

- (1) 40% of your coverage (if you have children) (2) 50% of your coverage (if you don't have children)

- your dependent children will be insured for

- (1) 10% of your coverage (if you have a spouse) (2) 15% of your coverage (if you do not have a spouse)

Employee Plan:

If the cost is .036/1000 then - $.036 \times 50 = \$1.80$ per month.

Family Plan:

is .045/1000 then - $.045 \times 50 = \$2.25$ per month.

The schedule of losses is as follows:

- Life _____		100% of approved benefit
- both hands or feet		
- sight of both eyes		
- one hand & one foot		
- one hand or foot & sight of one eye		
- use of both hands, both arms or both legs		
- paraplegia		
- hemiplegia		
- quadriplegia. _____		
- One arm or leg _____		75% of approved benefit
- use of one arm or leg. _____		
- One hand or foot _____		50% of approved benefit
- sight of one eye		
- speech		
- hearing in both ears		
- use of one hand. _____		
- Thumb & index finger (of same hand). _____		25% of approved benefit
- Hearing in one ear. _____		16.7% of approved benefit

How Do I Apply?

To apply, please complete the application form and forward to:

The Co-operators
Group Administration Department
1920 College Avenue
Regina, Saskatchewan
S4P 1C4

Your coverage will take effect once you receive written confirmation from The Co-operators.

Employees' premium payment is made by payroll deduction.

For more information and application forms contact your Plan Administrator.

Optional Accidental Death and Dismemberment - Application

Underwritten by Co-operators Life Insurance Company

Please Print

EMPLOYEE:			
<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	Month	Day Year
Last Name	First Name	Middle Initial	
ADDRESS:			
Street	City	Province	Postal Code
PLAN:	<input type="checkbox"/> Employee Plan	<input type="checkbox"/> Family Plan	AMOUNT OF INSURANCE APPLIED FOR:
I apply for the optional coverage under Group number _____ Account number _____ issued by Co-operators Life Insurance Company, and authorize my employer to deduct regularly from my salary any contribution required by me. The beneficiary of this insurance is as designated on my enrollment form for Group Life Insurance.			
NAME OF EMPLOYER:			
QUESTIONS TO BE ANSWERED BY THE APPLICANT:			
1. In the past two years: (a) Have you used marijuana, or sedative, tranquilizing, hallucinogenic or narcotic drugs, other than as prescribed by a physician? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please circle applicable item(s). (b) Have you taken, or been advised to take, treatment or counselling for alcohol abuse (including becoming a member of Alcoholics Anonymous)? <input type="checkbox"/> Yes <input type="checkbox"/> No			
2. What is your average alcohol consumption? Frequency of use: <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other _____ Amount consumed on each occasion _____ Date last used _____			
3. In the past two years, have you been treated for or had any indication of dizziness, fainting, convulsions, nervous breakdown, epilepsy, stroke or disorder of the brain or nervous system, or disorder of the eyes or ears? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please circle the applicable condition(s) and provide details below.			

PLEASE COMPLETE QUESTIONS ON NEXT PAGE.

Co-operators Life Insurance Company Privacy Statement

Co-operators Life Insurance Company (“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.

Applicant Declaration and Authorization

I hereby authorize any physician, hospital, clinic or any other medical or health care provider or facility, any insurance company, provincial health insurance plan, government department or agency, or any other person or organization having any medical or other relevant personal information or records regarding me to release to and exchange with Co-operators, the group plan administrator or their representatives and/or agents, any and all such information necessary for any or all of the following purposes: to underwrite my Application for insurance coverage, evaluate my eligibility for coverage and adjudicate all claims.

I further authorize Co-operators, the group plan administrator or their representatives and/or agents to request I undergo any such medical or paramedical examination(s) or evaluation(s) as may be required for such purposes.

I understand that my refusal or withdrawal of consent may result in the delay or denial of my Application.

I acknowledge that any information obtained from any paramedical or medical examination, any medical evidence form(s), questionnaire(s) or any other written statements completed and furnished as evidence of insurability shall form part of this Application and I declare that all such information and the information provided in this Application to be true, complete and accurate.

I acknowledge that any failure to disclose or any misrepresentation of any material fact may void the policy.

This authorization shall remain valid until revoked in writing by me. Any copy of this authorization shall be as valid as the original.

Date _____ Employee Signature _____

