the co-operators®
A Better Place For You®

GROUP BENEFITS
PLAN MEMBER CHANGE FORM

CO-OP®

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

1. GENERAL INFORMATION

This section is mandatory

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

Group **369** Account **00191** Certificate _____

Co-operative Name _____

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

2. PLAN ADMINISTRATOR SECTION Please check off appropriate box(es)

This section to be signed by the Plan Administrator

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

Retain a copy for your records

☐ SALARY, OCCUPATION OR RE-INSTATEMENT

Re-instatement Date _____ (MMM/DD/YYYY) ☐ Full-Time ☐ Part-time ☐ Contract

Occupation _____ Class _____ Salary $ _____

Hours per week _____ ☐ Hourly ☐ Weekly ☐ Bi-weekly ☐ Semi-monthly ☐ Monthly ☐ Annually

☐ BENEFIT CHANGES

To be completed by upload accounts only. The plan member listed below is eligible for the following benefits:

GROUP LIFE	DEPENDENT LIFE (not applicable to SK Plan B)	LONG TERM DISABILITY (not applicable to SK Plan B)	DENTAL	EXTENDED HEALTH CARE
Date Eligible: _____ MMM/DD/YYYY	Date Eligible: _____ MMM/DD/YYYY	Date Eligible: _____ MMM/DD/YYYY	Date Eligible: _____ MMM/DD/YYYY	Date Eligible: _____ MMM/DD/YYYY
☐ Plan B - Part-time *(SK only)*	☐ Spouse ☐ Child	☐ Plan 321 - 90 day elimination (FCL) ☐ 14 day elimination (Retail) ☐ 90 day elimination (Retail) ☐ Taxable, 67% ☐ Non-Taxable, 60% ☐ Termination Age 65 ☐ Termination Age 60	☐ Single ☐ Couple ☐ Family ☐ Plan B - Part-time *(SK only)* Single	☐ Single ☐ Family ☐ Plan B - Part-time *(SK only)* Single ☐ Plan B - Part-time *(SK only)* Family

☐ TERMINATION

I confirm that this employee is no longer eligible for coverage because _____

Plan Administrator Name _____ (First Name) _____ (Last Name)

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

Plan Administrator Email _____ Phone Number (_____) _____

3. PLAN MEMBER SECTION Please check off appropriate box(es)

☐ NAME, ADDRESS, MARITAL STATUS

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

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

Date of Birth _____ (MMM/DD/YYYY)

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

*Date of Marriage _____ (MMM/DD/YYYY) **Cohabitating since: _____ (MMM/DD/YYYY)

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

SPOUSE ☐ ADD ☐ REMOVE

Spouse _____ (First Name) _____ (Middle) _____ (Last Name)

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

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

You must notify your Benefits Administrator if there are any changes in student status. You must verify your child's student status by submitting confirmation of enrolment by June 30th of each year.

DEPENDENT(S) ☐ ADD ☐ REMOVE

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

☐ Male ☐ Female ☐ Full-time student ☐ Disabled Dependent**

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

☐ Male ☐ Female ☐ Full-time student ☐ Disabled Dependent**

3. PLAN MEMBER SECTION (CONTINUED)

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.

All changes must be initialled by the Plan Member.

If no trustee is named for minor children, the funds are paid to the Public Trustee (or equivalent government official) until the children reach the age of majority.

In Quebec, the Civil code provisions apply. It is not necessary to designate a trustee. The benefits will be paid directly to the child's tutor, without the requirement for a designation of a trustee.

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

☐ BENEFICIARY CHANGE

Change applies only to checked coverages: ☐ Basic Life/AD&D ☐ Optional Life ☐ Optional AD&D ☐ Paid Up Certificate ☐ All

I, _____ revoke all previous designations for the coverage checked above and declare that all benefits payable under the Policy after my death for the coverage checked, shall be paid to the following:

PRIMARY BENEFICIARY(IES) % Allocated

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

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

CONTINGENT BENEFICIARY % Allocated

_____ (First Name) _____ (Middle) _____ (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) _____ (Middle) _____ (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

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 spouse are eligible for the following benefits from another source or company.
☐ Extended Health Care and Dental Coverage ☐ Extended Health Care Coverage ONLY ☐ Dental Coverage ONLY

☐ Co-ordination of Benefits has been added

☐ Co-ordination of Benefits has been terminated

To add these benefits at a later date, you must apply for coverage within 31 days of loss of spousal coverage. When applying for coverage, proof must be provided of the spousal termination. 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.

☐ REFUSAL OF BENEFITS

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

Spouse's Insurer _____

Please ensure you have attached proof of this termination.

☐ ADDITION OF BENEFITS

You may add Extended Health Care and/or Dental benefits if your spouse has lost coverage. Effective Date of loss of coverage under your spouse's plan: _____ (MMM/DD/YYYY) . Benefits being added:

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

4. PRIVACY AND PLAN MEMBER SIGNATURE

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.

I have read and understood the privacy section 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.

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