the co-operators
A Better Place For You®

GROUP BENEFITS
EXTENDED HEALTH CARE CLAIM FORM

INSTRUCTIONS

Use this form for all medical expenses and services. Please print clearly and be sure all sections are complete to avoid delays in processing your claim. Attach the original receipts for each expense claimed and retain a copy for your records.

Mail your completed form to:
Co-operators Life Insurance Company
Extended Health Care Claims
1920 College Avenue
Regina, SK S4P 1C4

HEALTH SPENDING ACCOUNT

If your plan provides a Health Spending Account, should any unpaid balance of this claim be reimbursed under your account? ☐ Yes ☐ No

DIRECT DEPOSIT AND ELECTRONIC CLAIM STATEMENT

You will receive your claim payments faster with direct deposit and enjoy the convenience of seeing your claim statements online.

Sign up for direct deposit and electronic claim statements by calling our Client Service Centre at 1-800-667-8164 or signing in to Benefits Now™.

PART 1 - PLAN MEMBER INFORMATION

Group ______________ Account ________________ Certificate ____________________ Plan Sponsor/Employer ______________________________

Plan Member ________________________________ _____ __________________________________ Date of Birth _______________________
First Name | Initial | Last Name | MMM/DD/YYYY

Address ______________________________ _________________________ _______ _________ Email ________________________________
Street | City | Province | Postal Code

PART 2 - CLAIM INFORMATION

List the name of all persons for whom you are claiming expenses. Add up all the receipts and insert the total amount claimed.
Attach original reciepts and ensure each receipt clearly indicates the type of expense being claimed.

Name of Person Incurring Expense	Date of Birth MMM/DD/YYYY	Relationship to Plan Member	Full-time Student	Disabled Dependent	Amount Claimed
			☐ Yes ☐ No	☐ Yes ☐ No	
			☐ Yes ☐ No	☐ Yes ☐ No	
			☐ Yes ☐ No	☐ Yes ☐ No	
			☐ Yes ☐ No	☐ Yes ☐ No	
			☐ Yes ☐ No	☐ Yes ☐ No	
			☐ Yes ☐ No	☐ Yes ☐ No	
			☐ Yes ☐ No	☐ Yes ☐ No	
			☐ Yes ☐ No	☐ Yes ☐ No	
				Total Amount Claimed	$

PART 3 - CO-ORDINATION OF BENEFITS

If this expense has been considered by another carrier, you **must** attach the original explanation of benefits from that plan along with **copies** of the receipts.

Are you or your dependents covered by another plan? ☐ Yes ☐ No If yes, provide the following:

Spouse Date of Birth _____ ________________ Insurance Company Name/Source: ____________________________ Policy:___________________
Day | Month

If your spouse's benefit plan is with Co-operators Life Insurance Company, do you want us to process the claim through both benefit plans? ☐ Yes ☐ No

Spouse's Policy ____ Certificate ___________________________________

PART 4 - PLAN SPONSOR AUTHORIZATION (ONLY IF REQUIRED)

Employment Date __________________ Employee's/Member's Effective Date ____________________ Dependent's Effective Date __________________
MMM/DD/YYYY | MMM/DD/YYYY | MMM/DD/YYYY

Termination Date (if applicable) __________________ Retirement Date ___________________ Status ☐ Single ☐ Couple ☐ Family
MMM/DD/YYYY | MMM/DD/YYYY

Signature of Authorized Official ____ Date __________________________
MMM/DD/YYYY

(SEE REVERSE)

PART 5 - PRIVACY AND AUTHORIZATION

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 dependent to release to and exchange with Co-operators Life Insurance Company, 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 benefits plan. I confirm that I am authorized to act on behalf of my spouse and/or dependents for such purposes. Any copy of this authorization shall be as valid as the original.

In the event there is suspicion and/or evidence of fraud and/or plan abuse concerning this claim, I acknowledge and agree that Co-operators Life Insurance Company may investigate and that information about me, my spouse and/or dependents pertaining to this claim may be used and disclosed to any relevant organization including regulatory bodies, government organizations, medical suppliers, and other insurers, and where applicable my Plan Sponsor, for the purpose of investigation and prevention of fraud and/or plan abuse.

If Co-operators Life Insurance Company pays me an amount that exceeds the benefit(s) to which I am entitled under my plan (the Overpayment Amount), then I acknowledge and agree that: (a) I am indebted to Co-operators Life Insurance Company for the Overpayment amount (b) Co-operators Life Insurance Company has the right to recover the Overpayment Amount through any means available by law, and (c) Co-operators Life Insurance Company will offset any benefits payable to me by the Overpayment Amount until Co-operators Life Insurance Company has recovered the Overpayment Amount in full.

Plan Member Signature ______________________________ Date ______________
MMM/DD/YYYY

CO-OPERATORS LIFE INSURANCE COMPANY
1920 COLLEGE AVENUE REGINA SK S4P 1C4