the co-operators

MAIL TO: Group Extended Health Care Claims
The Co-operators, 1920 College Ave., Regina, SK S4P 1C4

EXTENDED HEALTH CLAIM FORM

INSTRUCTIONS

1. Complete the section headed "Description of Expenses".
2. Remember to include a copy of the "Physician's Recommendation", if required.
3. 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	SEX	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.	PID #	Name of Employer/Policyholder

1. Employee's/Members's name _____ Previous name (if applicable) _____
(first) (initial) (last)
2. Employee's/Members's mailing address _____
(Street) (City) (Prov) (Postal Code)
3. Date of Birth D _____/M _____/Y _____
4. Are benefits for any of these expenses payable from any other company or Worker's Compensation? ❑ Yes ❑ No
If "YES", name company or source _____ Spouse's date of birth 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. If claimant is a student over the age 18, name of student _____, 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

If claimant is a student over the age 18, name of student _____, 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

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.

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 _____ X _____
Employee's/Member's Signature Date

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 (D/M/Y) (If applicable)

Signature of Employer/Plan Administrator Official	Classification	Date
X		