the co-operators
A Better Place For You®

GROUP BENEFITS COST PLUS CLAIM FORM

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

INSTRUCTIONS

With your original claim form, include all supporting invoices and payment covering the total claim amount (Section 2: E).

Payment can be made by a cheque made payable to Co-operators Life Insurance Company or through the convenience of PAD (complete section 5).

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

INFORMATION

Expenses must qualify for the Medical Expense Tax Credit under section 118.2 of the Canadian Income Tax Act or Extended Health Care and Dental Care expenses that Co-operators Life Insurance Company deems eligible medical expenses under a private health services plan or a group accident and sickness plan. CRA may not consider some of the expenses submitted as eligible expenses. Please consult your tax advisor for further clarification.

Claims paid under cost plus will not be charged to plan experience and will be excluded for renewal purposes. Eligibility for cost plus benefits is determined by the Group Policyholder; therefore, it is the Group Policyholder's responsibility to verify Plan Member and Dependent eligibility prior to claims submissions. To qualify, expenses must be incurred and submitted in the current or previous calendar year.

1. PLAN MEMBER INFORMATION

Group ______________ Account ______________ Certificate ______________

Plan Sponsor/Employer ______________

Plan Member ______________ (First Name) ______ (Initial) ______________ (Last Name)

2. EXPENSES

Type of Expense	Amount Claimed		
	$		
	$		
	$		
	$		
	$		
Total Amount Claimed	$	A	
Administration Charge	$	B	(10% of A) (Maximum $250, Minimum $25)
Subtotal	$	C	(A + B)
Provincial Sales Tax*	$	D	ON 8%, QC 9%
Total	$	E	(C + D)

3. DISCLAIMER

Co-operators Life Insurance Company acts as the administrator and not as the insurer of the Cost Plus plan. The policyholder is financially and legally liable for all Cost Plus claims submitted to Co-operators Life Insurance Company. The policyholder accepts full responsibility for any tax consequences related to this reimbursement. Co-operators Life Insurance Company makes no representation or warranty as to the eligibility of any Cost Plus claims under the Income Tax Act for any medical expense tax credit and has no responsibility for any expenses deemed ineligible by CRA for such credit.

4. POLICYHOLDER DECLARATION AND ACKNOWLEDGMENT

The policyholder affirms that the information provided here and in all of the attached documents is true and Co-operators Life Insurance Company can rely on this information to process this claim. The policyholder acknowledges that:

1. Co-operators Life Insurance Company will not evaluate the eligibility of the expenses claimed for tax purposes;
2. Co-operators Life Insurance Company did not provide any advice, including tax advice, concerning the administration of this claim; and
3. The plan sponsor retains the financial and legal liability for the Cost Plus claim to the plan member, including any payroll related taxes or deductions, as well as all expenses incurred in connection with Co-operators Life Insurance Company's administration of this Cost Plus claim.

A cheque for the total (E) payable to Co-operators Life Insurance Company or the completed payment section (Section 5) is enclosed, together with all receipts pertaining to the amount being claimed. I understand that Co-operators Life Insurance Company will issue a cheque payable to the plan member.

I, have read all of the information and request that the expenses outlined be reimbursed on a cost plus basis.

Approved By ______________ (Authorized signing official of the Policyholder) Date ______________ (MMM/DD/YYYY)

Title ______________

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.

(SEE OVER)

5. PAYMENT SECTION – PRE-AUTHORIZED DEBIT (PAD) PLAN

I request and authorize Co-operators Life Insurance Company to make withdrawals against the bank, credit union or trust company account specified, or any account subsequently named by me, and such banking institution to process these withdrawals as if I had signed them, for the purpose of collecting payment under this policy. If the said account is replaced by an account in another banking institution, this request and authorization shall also apply to such other banking institution. **I have waived my right to receive pre-notification of the amount of the PAD and agreed that I do not require advance notice of the amount of the PADs before the debit is processed.**

Financial Institution Name ______________________________

Address ______________________ (Street) ______________________ (City) ________ (Province) ________ (Postal Code)

Transit ____________ (5 digits) Institution ________ (3 digits) Account ____________________ (12 digits)

NOTE: the PAD withdrawals are the 1st of each month. The date the PAD cheque clears your account can be anywhere from one to ten days after the deduction date (this depends on the residence location of the payor and the clearing facility of each individual financial institution).

Your Payor's PAD agreement may be cancelled provided notice is received 14 days before the next scheduled PAD. If any of the above details are incorrect, please contact us immediately at 1-800-667-8164. If the details are correct, you do not need to do anything further and your Pre-Authorized Debits will be processed and start on the Payment Start Date indicated above. You have certain recourse rights if any debit does not comply with this agreement. For example, you have the right to receive reimbursement for any PAD that is not authorized or is not consistent with the terms of this PAD agreement. To obtain more information on your recourse rights, contact your financial institution or visit www.payments.ca.

I hereby authorize Co-operators Life Insurance Company to withdraw payments from my account for the policy referred to herein and to exchange my relevant financial information with my financial institution for such purpose. This authorization shall remain valid for so long as my coverage remains in effect unless revoked by me in writing. Any copy of this authorization shall be as valid as the original.

Bank Depositor Signature ______________________________ Date ______________ (MMM/DD/YYYY)

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