the co-operators®
A Better Place For You®

GROUP BENEFITS PLAN MEMBER ENROLMENT FORM

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

1. EMPLOYMENT INFORMATION

To be completed by the Plan Administrator

The Plan Administrator must confirm eligibility prior to completing this form.

If enrolment is not made on time, coverage may be limited or denied based on proof of insurability. Late Applicants must complete and attach the Health Evidence Questionnaire (GL1364).

Retain a copy for your records

Group _____ Account _____ Class _____ Certificate _____

Group Name Futuretek

Employment Commenced May 10, 2023 (MMM/DD/YYYY) ● Full-time ○ Part-time ○ Contract

Salary $ 60,000. Hrs per week 40 ☐ Hourly ☐ Weekly ☐ Bi-weekly ☐ Semi-monthly ☐ Monthly ☐ Annually

Occupation IT Instructor Province of Residence _____ Province of Employment ON

Does the plan member and/or dependent(s) have valid Provincial Health Plan coverage? ☐ Yes ☐ No

☐ Health Spending Account (if applicable) Deposit Amount $ _____

I confirm this plan member is actively working the minimum number of hours indicated in the Policy and is presently living in Canada. I certify that all the information provided herein is complete and accurate.

Signature Elena Ricci (Plan Administrator) Date 05/31/2023 (MMM/DD/YYYY)

Plan Administrator Email _____ Phone Number (_____) _____

2. PLAN MEMBER INFORMATION

To be completed by the Plan Member

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

Plan Member Akeel (First Name) A (Middle) Lashley (Last Name)

Address 14 Bergamot Ave (Street) Toronto (City) ON (Province) M9W 1V9 (Postal Code)

Date of Birth 03/14-01 (MMM/DD/YYYY) ● Male ○ Female Provincial Health Plan coverage? ● Yes ○ No

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

*Co-habitating since: _____ (MMM/DD/YYYY)

3. REFUSAL OF BENEFITS

Does your spouse have coverage from another provider? ○ Yes* ● No ***Option to co-ordinate plans on next page**

To be completed by the Plan Member

To add these benefits at a later date, you must apply for coverage within 31 days of loss of spousal coverage. 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.

Coverage for Extended Health Care and Dental can be refused if you and/or your spouse/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 _____

4. DEPENDENT INFORMATION

Adding a spouse to your plan? ○ Yes ● No Adding any dependent(s)? ● No ○ 1 ○ 2 ○ 3 ○ 4

To be completed by the Plan Member

This information is required if your plan includes Extended Health Care, Dental and/or Dependent Life coverage.

If there are more than four dependents, please attach a separate list.

**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 Co-operators Life Insurance Company 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.

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

Date of Birth _____ (MMM/DD/YYYY) ☐ Male ☐ Female Provincial Health Plan coverage? ☐ Yes ☐ No

ELIGIBLE DEPENDENT(S)

1. _____ (First Name) _____ (Middle) _____ (Last Name) Date of Birth _____ (MMM/DD/YYYY)
☐ Male ☐ Female ☐ Post-secondary Student ☐ Disabled Dependent** Provincial Health Plan coverage? ☐ Yes ☐ No

2. _____ (First Name) _____ (Middle) _____ (Last Name) Date of Birth _____ (MMM/DD/YYYY)
☐ Male ☐ Female ☐ Post-secondary Student ☐ Disabled Dependent** Provincial Health Plan coverage? ☐ Yes ☐ No

3. _____ (First Name) _____ (Middle) _____ (Last Name) Date of Birth _____ (MMM/DD/YYYY)
☐ Male ☐ Female ☐ Post-secondary Student ☐ Disabled Dependent** Provincial Health Plan coverage? ☐ Yes ☐ No

4. _____ (First Name) _____ (Middle) _____ (Last Name) Date of Birth _____ (MMM/DD/YYYY)
☐ Male ☐ Female ☐ Post-secondary Student ☐ Disabled Dependent** Provincial Health Plan coverage? ☐ Yes ☐ No

4. DEPENDENT INFORMATION (CONTINUED)

If Co-ordination of Benefits is terminated or changed, notification is required within 31 days.

CO-ORDINATION OF BENEFITS

Complete this section if your plan includes Extended Health Care and/or Dental and you have not refused such coverage for your spouse/dependents in section 3.

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

5. BENEFICIARY INFORMATION

How many beneficiary(ies) would you like to add? ○ None(Estate) ● 1 ○ 2 ○ 3

To be completed by the Plan Member

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.

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

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.

PRIMARY BENEFICIARY(IES)

First Name	Middle	Last Name	Relationship	% Allocated
Nadine	A	Lashley	Mother	100 %
				%
				%

CONTINGENT BENEFICIARY

First Name	Middle	Last Name	Relationship	% Allocated
Anaita	N	Lashley	Sister	100 %

In provinces other than Quebec, if a designated beneficiary is a minor, please name a trustee. Insurance proceed 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
	Akeem	J	Lashley	Brother

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

6. PRIVACY

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.

7. PLAN MEMBER SIGNATURE

To be signed by the Plan Member

I have read and understood the section entitled "Privacy" 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.

Signature Akeel Lashley Date 05/24/2023 (MMM/DD/YYYY)