

STUDENT ELIGIBILITY FORM

EMPLOYEE/MEMBER INFORMATION

Employee/Member's Name _____

Group Policy No. _____ Account No. _____ PID No. _____

DEPENDENT INFORMATION

1. Dependent Student's Name _____ Date of Birth ____/____/____
MM DD YY

2. Name of School in attendance _____

Address _____

Phone No. of Registrar's office () _____ - _____ Fax. No. () _____ - _____

3. Student Status: Full-time Part-time Correspondence

4. Student is enrolled in the semester starting ____/____/____ and ending ____/____/____
MM DD YY MM DD YY

5. Will student be graduating at the end of the semester indicated above? Yes No

NOTE: Declaration MUST be provided prior to each semester the dependent attends school.

***PLEASE RETURN THE COMPLETED FORM TO YOUR
HUMAN RESOURCES/PAYROLL DEPARTMENT.***

DECLARATION

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 declare that the information contained herein is true, complete and accurate and understand that the submission of false or incomplete information may result in denial of coverage or the delay or denial of any claim.

I hereby authorize the above-named educational institution to release to and exchange with Co-operators Life Insurance Company, the group plan administrator or their representatives or agents any and all information or records regarding my dependant's student enrollment status. I understand such information may be necessary to determine my dependant's eligibility for coverage, adjudicate all claims and administer the group benefit plan. I confirm that I am authorized to act on behalf of my dependant for such purposes.

Any copy of this authorization shall be as valid as the original.

Employee/Member Signature

Date

Fax Number: (306) 347-6812