the co-operators
A Better Place For You®

GROUP BENEFITS
CRITICAL ILLNESS - PHYSICIAN STATEMENT
AORTIC SURGERY
CORONARY ANGIOPLASTY
HEART VALVE REPAIR/REPLACEMENT

MAILING ADDRESS

Mail: Co-operators Life Insurance Company
Life Claims Department
1920 College Avenue
Regina SK S4P 1C4

Phone: 1-866-442-3098

Fax: 1-866-889-9925

INSTRUCTIONS

Please print clearly and be sure all sections are complete to avoid delays in processing the claim.

The confidential Medical Information section is to be completed by your specialist.

The Patient is responsible for the cost of completing this form.

Condition(s) listed above may or may not be covered under your Policy. **Please refer to your Group Contract to confirm coverage for the condition claimed.**

The completed form must be faxed directly from the Physician's office or the original can be mailed to the address provided.

1. PATIENT INFORMATION (TO BE COMPLETED BY PATIENT)

Patient _____ (First Name) _____ (Initial) _____ (Last Name) Date of Birth _____ (MMM/DD/YYYY)

Group _____ Account _____ Certificate _____

2. MEDICAL INFORMATION (TO BE COMPLETED BY THE PHYSICIAN)

1. **PLEASE PROVIDE COPIES OF YOUR OFFICE RECORDS, INVESTIGATIONS PERFORMED (IE. ECG TRACINGS OR PRE-OPERATIVE ANGIOGRAPHY), DIAGNOSTICS, CONSULTATION REPORTS, SURGICAL OR PATHOLOGY REPORTS AND HOSPITALIZATION SUMMARIES.**

2. Indicate your diagnosis for this patient:

_____

_____

_____

3. What type of surgery is required for this patient?

_____

_____

_____

4. Have there been symptoms that led to the recommendation of this surgery? ☐ Yes ☐ No

   If yes, please describe the symptoms, severity and onset date:

Symptom	Onset Date MMM/DD/YYYY	Severity

5. Indicate the tests or procedures used to diagnose this patient's pre-surgical condition:

_____

_____

_____

6. Date you were first consulted for this condition _____ (MMM/DD/YYYY)

7. Date of Diagnosis _____ (MMM/DD/YYYY)

8. Date Patient was Advised of Diagnosis _____ (MMM/DD/YYYY)

2. MEDICAL INFORMATION (CONTINUED)

9. What type of surgery has been performed and when? (Ie. If coronary artery bypass grafting, please state the number of sites and grafts.)

_____

_____

_____

10. Please provide details of the post-surgical treatment protocol:

_____

_____

_____

11. Please provide the address of the hospital where the operation took place and also the name of the surgeon; together with the names of any other consultants involved with your patient's treatment:

_____

_____

_____

12. To the best of your knowledge, has this patient had any history of high blood pressure, high cholesterol, chest pain, diabetes or other pre-cursors for heart disease? ☐ Yes ☐ No

If yes, please provide details and dates:

_____

_____

_____

13. Is there any record of related illnesses in the patient's family history? ☐ Yes ☐ No

If yes, please provide details:

_____

_____

_____

14. Please provide details of anything in the patient's habits, personal medical history or family history which would have increased the risk or contributed to his/her condition:

_____

_____

_____

15. Does the patient currently use or has the patient ever used any form of tobacco, marijuana, nicotine products or nicotine substitute (nicotine products including cigarettes, cigarillos, cigars, pipes, chewing tobacco, snuff, nicotine gum or patch or any other nicotine products)? ☐ Yes ☐ No

If yes, which substance(s) are or were used? _____

What quantity or number are or were used per day? _____ Date last used _____
MMM/DD/YYYY

16. Please provide the name and address of all consultants, specialists or hospitals to which your patient has been referred or attended for this condition:

_____

_____

17. Please provide any information you feel would be relevant to our review of your patient's claim for benefits:

_____

_____

_____

3. PHYSICIAN INFORMATION AND AUTHORIZATION

I hereby certify that the information provided in this request is true, complete and accurate. I acknowledge that the information in this statement will be kept in a claim file with the insurer and might be accessible by the patient or third parties to whom access has been granted or those authorized by law.

Our contract requires that a covered illness be diagnosed by a Medical Practitioner who cannot be:

a) the Life Insured,
b) related to the Life Insured, or
c) a business associate of the Life Insured.

Is your relationship to the Life Insured either a, b or c? ☐ Yes ☐ No

Physician _____ _____ _____
First Name Initial Last Name

Specialty _____

Physician's Stamp

Address _____ _____ _____ _____
Street City Province Postal Code

Telephone Number (_____) _____ Fax Number (_____)_____

Physician Signature _____ Date _____
MMM/DD/YYYY

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.