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A Better Place For You®

GROUP BENEFITS
CRITICAL ILLNESS - PHYSICIAN STATEMENT
CEREBRAL PALSY

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 physician.

The Patient's parent/legal guardian 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 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 _____ _____ _____ Date of Birth _____
First Name Initial Last Name 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 (INCLUDING MRI, CRANIAL ULTRASOUND, CT SCAN, EEG, LAB TESTS AND ALL TESTS FOR HEARING, VISION, MOTOR DEVELOPMENT, RESPIRATIONS AND COMMUNICATION DELAYS), DIAGNOSTICS, CONSULTATION REPORTS AND HOSPITALIZATION SUMMARIES.**

2. Indicate the diagnosis for this patient:

_____

_____

_____

3. Was this diagnosis made by a Pediatric Neurologist in Canada? ☐ Yes ☐ No

Please provide name of physician: _____

4. Date of Diagnosis _____
MMM/DD/YYYY

5. Date the diagnosis or possible diagnosis of Cerebral Palsy was first discussed with the parent/guardian of this patient _____
MMM/DD/YYYY

6. Are you the patient's usual physician? ☐ Yes ☐ No

If no, please provide the full name and address of this patient's usual physician:

_____

_____

_____

7. Date when any of the following typical symptoms first appeared:

☐ Vision Impairment _____
MMM/DD/YYYY

☐ Hearing Impairment _____
MMM/DD/YYYY

☐ Speech Delays or Impairments _____
MMM/DD/YYYY

☐ Intellectual Disabilities _____
MMM/DD/YYYY

☐ Motor Delay _____
MMM/DD/YYYY

8. Date you were first consulted regarding this illness _____
MMM/DD/YYYY

2. MEDICAL INFORMATION (CONTINUED)

9. What tests were conducted to make this diagnosis?

10. Please provide details on how Cerebral Palsy has affected either one limb, one side of the body, the whole body or other:

11. Please describe the patient's current clinical presentation (e.g. weakness, spasticity, mental and motor impairment) and the treatment protocol:

12. Has there been a referral to any treatment facility, specialized medical facility or care provider for on-going care? ☐ Yes ☐ No

    If yes, please provide details including dates(s) and location(s):

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

    If yes, state relationship of relative, nature of illness and the age at which the illness was diagnosed:

14. Were there factors during pregnancy or birth that were associated with the eventual onset of Cerebral Palsy? ☐ Yes ☐ No

    If yes, please provide details:

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

16. 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.