

GROUP BENEFITS

CRITICAL ILLNESS - PHYSICIAN STATEMENT

CONGENITAL HEART DISEASE

MAILING ADDRESS	INSTRUCTIONS
<p>Mail: Co-operators Life Insurance Company Life Claims Department 1920 College Avenue Regina SK S4P 1C4</p> <p>Phone: 1-866-442-3098</p> <p>Fax: 1-866-889-9925</p>	<p>Please print clearly and be sure all sections are complete to avoid delays in processing the claim.</p> <p>The confidential Medical Information section is to be completed by your physician.</p> <p>The Patient's parent/legal guardian is responsible for the cost of completing this form.</p> <p>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.</p> <p>The completed form must be faxed directly from the Physician's office or the original can be mailed to the address provided.</p>

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 ECHOCARDIOGRAM OR TRANSESOPHAGEAL ECHOCARDIOGRAM (TEE), CARDIAC CATHETERIZATION, CHEST X-RAY, ECG OR EKG, MRI), LAB WORK, DIAGNOSTICS, CONSULTATION REPORTS AND HOSPITALIZATION SUMMARIES.

2. Indicate the diagnosis for this patient:

3. Date of Diagnosis _____
MMM/DD/YYYY

4. Was this diagnosis made by a Pediatric Cardiologist in Canada? Yes No
 Please provide name of physician: _____

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

6. When was the disease diagnosed? Pre-Natal Post-Delivery

7. Are you the patient's usual physician? Yes No
 If no, please provide the full name and address of this patient's usual physician:

8. Which of the following were observed in your patient that led to the diagnosis:
 Easily Fatigued
 Rapid Breathing
 Poor Blood Circulation
 Cyanosis
 Other (ie. prenatal ultrasound) _____

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

10. Please describe the patient's current clinical presentation and treatment protocol:

2. MEDICAL INFORMATION (CONTINUED)

11. 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:

12. Please provide details of anything in the patient's personal medical history (including prenatal, birth, maternal or chromosomal history) or family history which would have increased the risk or contributed to his/her condition:

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

14. 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 _____

Address _____
Street City Province Postal Code

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

Physician Signature _____ Date _____
MMM/DD/YYYY

Physician's Stamp

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.