

GROUP BENEFITS

CRITICAL ILLNESS - PHYSICIAN STATEMENT

LOSS OF LIMBS

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 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, CONSULTATION REPORTS AND HOSPITALIZATION SUMMARIES.

2. Please indicate the current condition of this patient (at home, in a care facility etc.):

3. Please indicate which limbs have been severed, and whether the total or partial limb was removed:

4. Date Incident/Surgery Occurred _____
MMM/DD/YYYY

5. Were limbs lost due to an **accident**? Yes No

If yes, please provide details and dates:

6. Were limbs removed due to an **illness**? Yes No

If yes, please describe the underlying illness or symptoms prior to the surgery:

When was the condition first diagnosed and by whom? _____

Date Patient was Advised of Diagnosis _____
MMM/DD/YYYY

2. MEDICAL INFORMATION (CONTINUED)

7. Did this condition result from any other factors such as complications of surgery, diabetes or other condition OR did the incident/surgery result from ingestion of drugs (prescribed or not prescribed), alcohol, intravenously introduced substance, mental-nervous condition or self-inflicted injury? Yes No

If yes, please provide details:

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

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

9. Is there any record of any related previous condition or similar illness in the patient's medical history? Yes No

If yes, please provide details:

10. Is there any record of related illnesses in the patient's family history, or any other related family history? Yes No

If yes, please provide details:

11. 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:

12. 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

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.