the co-operators®
A Better Place For You®

GROUP BENEFITS
CRITICAL ILLNESS - PHYSICIAN STATEMENT
LOSS OF SPEECH

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 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, CONSULTATION REPORTS AND HOSPITALIZATION SUMMARIES.**

2. Indicate your diagnosis for this patient:

_____

_____

_____

3. This condition is the result of:

☐ Accident

Please provide dates and details:

_____

_____

_____

☐ Disease

Please provide dates and details:

_____

_____

_____

☐ Degenerative Process

Please provide dates and details:

_____

_____

_____

4. Date of Diagnosis _____
MMM/DD/YYYY

5. What tests or procedures were conducted to make the diagnosis?

_____

_____

_____

2. MEDICAL INFORMATION (CONTINUED)

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

7. What treatment has been undertaken for this condition?

_____

_____

_____

8. What is your prognosis for this patient with respect to:

a) Partial recovery of speech

_____

_____

_____

b) Full recovery of speech

_____

_____

_____

9. 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:

_____

_____

_____

10. Did this condition result from any other factors such as a stroke, tumour, cancer 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:

_____

_____

_____

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 _____

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.