

GROUP BENEFITS

CRITICAL ILLNESS - PHYSICIAN STATEMENT

OCCUPATIONAL HIV INFECTION

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 Group 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 OFFICE RECORDS, INVESTIGATIONS/TESTS PERFORMED, CONSULTATION REPORTS AND HOSPITAL SUMMARIES.

2. Date of incident which exposed the patient to contaminated body fluids? _____
(MMM/DD/YYYY)

3. Please provide full details of the method of transmission, and where the incident occurred:

4. Was an incident report completed by the Employer? Yes No

5. Do you know whether the incident was witnessed? Yes No

6. Date the patient first consulted you regarding this incident _____
(MMM/DD/YYYY)

7. How long has this person been your patient? _____

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. Please provide dates and results of all HIV or antibody tests performed:

Date <small>(MMM/DD/YYYY)</small>	Results

10. Date patient was first diagnosed as HIV positive _____
(MMM/DD/YYYY)

11. Date patient was first advised of the diagnosis _____
(MMM/DD/YYYY)

12. Who advised the patient of the diagnosis? _____

13. Had the patient taken any available licensed vaccine offering prevention against HIV? Yes No

If yes, please provide date: _____
(MMM/DD/YYYY)

2. MEDICAL INFORMATION (CONTINUED)

14. Was the incident reported in accordance with Canadian workplace guidelines? Yes No

If no, please provide details:

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 used 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's Stamp

Physician _____
First Name Initial Last Name

Specialty _____

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.