the co-operators
A Better Place For You®

GROUP BENEFITS
CRITICAL ILLNESS - PHYSICIAN STATEMENT
PARKINSON'S DISEASE

MAILING ADDRESS	INSTRUCTIONS
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	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 neurologist. 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 Group 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 ______________ (First Name) ______ (Initial) ______________ (Last Name) Date of Birth ______________ (MMM/DD/YYYY)

Group ______________ Account ______________ Certificate ______________

2. MEDICAL INFORMATION (TO BE COMPLETED BY THE PHYSICIAN)

1. **PLEASE PROVIDE COPIES OF YOUR OFFICE RECORDS, INVESTIGATIONS/TESTS PERFORMED, CONSULTATION REPORTS AND ALL HOSPITALIZATION SUMMARIES.**
2. Date Symptoms Began ______________ (MMM/DD/YYYY)
3. Please describe the symptoms:

____

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4. Date patient first consulted you for these symptoms ______________ (MMM/DD/YYYY)
5. How long has this person been your patient? ______________
6. Date the diagnosis of possible Parkinson's Disease was first discussed with the patient ______________ (MMM/DD/YYYY)
7. Date the diagnosis was confirmed ______________ (MMM/DD/YYYY)
8. Is the diagnosis Primary Idiopathic Parkinson's Disease? ☐ Yes ☐ No

   If yes, please provide the name and address of the specialist who confirmed the diagnosis:

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9. Please outline the clinical course and describe the patient's neurological signs and symptoms, providing dates and duration:

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2. MEDICAL INFORMATION (CONTINUED)

10. Please indicate the degree of assistance required by the patient to perform the Activity of Daily Living described. Check off only one box for each of these activities to specify the patient's current capacity level.

BATHING the ability to wash oneself in a bathtub, shower or by sponge bath, with or without the aid of equipment.

DRESSING the ability to put on and remove necessary clothing including braces, artificial limbs or other surgical appliances.

TOILETING the ability to get to and from the toilet and maintain personal hygiene.

BLADDER & BOWEL CONTINENCE the ability to manage bowel and bladder function with or without protective undergarments or surgical appliances so that a reasonable level of hygiene is maintained.

TRANSFERRING the ability to move in and out of a bed, chair or wheelchair, with or without the use of equipment.

FEEDING the ability to consume food that has already been prepared and made available, with or without the use of adaptive utensils.

Activity of Daily Living	Patient requires no assistance and performs the ADL independently	Patient requires some assistance each time he/she performs the ADL	Patient requires direct physical assistance each time he/she performs the ADL	On what date did the patient first require assistance (MMM/DD/YYYY)
Bathing				
Dressing				
Toileting				
Bladder/Bowel Continence				
Transferring				
Eating				

11. Please describe the patient's ability to perform these activities.

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

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13. Has the patient previously suffered from any predisposing disorders? ☐ Yes ☐ No

If yes, please provide details:

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14. a) Is there a family history of Parkinson's Disease? ☐ Yes ☐ No

If yes, please provide details:

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2. MEDICAL INFORMATION (CONTINUED)

14. b) Is there any other significant family history? ☐ Yes ☐ No

If yes, please provide details:

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15. 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:

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16. 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

17. Please provide any information you feel would be relevant to our review of your patient's claim for benefits:

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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.