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GROUP BENEFITS
SHORT TERM DISABILITY

ATTENDING PHYSICIAN'S STATEMENT FOR MENTAL HEALTH CONDITIONS

CONTACT INFORMATION

Mail: Co-operators Life Insurance Company
Disability Claims Department
1900 Albert Street
Regina, SK S4P 4K8

Fax: 1-866-889-9926

Email: disability_claims_admin@cooperators.ca

INSTRUCTIONS

Important note: Please ensure you complete the appropriate Attending Physician Statement form based on your patient's primary diagnosis. There are two forms, one for mental health conditions and one for all other conditions. Submission of the incorrect form could result in delays in processing your patient's claim.

The plan member is responsible for the cost of completing this form.

Medical Information is to be completed by the physician providing treatment.

PLAN MEMBER INFORMATION & AUTHORIZATION

Group _____ Account _____ Certificate _____

Plan Member _____ _____ _____ Telephone (_____) _____
First Name Initial Last Name

Date of Birth _____ Height _____ Weight _____
MMM/DD/YYY

If you would like Co-operators to communicate with you by email about this disability claim, please provide your email _____

You acknowledge that data transmitted over the internet may be intercepted and that such transmission is at your own risk. If you no longer wish to communicate with Co-operators Life Insurance Company by email, please send notification to disability_claims_admin@cooperators.ca.

Plan Sponsor/Employer Name _____ Telephone (_____) _____

I hereby authorize my physician to release any medical information supporting my claim for disability benefits to the plan administrator, the plan adjudicator and my insurer. I understand that I am responsible for obtaining this form and for any amounts charged by my physician to complete this form. Medical and health information excludes genetic test results.

Plan Member Signature _____ Date _____
MMM/DD/YYYY

MEDICAL INFORMATION (TO BE COMPLETED BY THE PHYSICIAN)

Please attach copies of chart notes, test results, and consultation reports.

DIAGNOSIS

Primary _____

Secondary _____

Has this diagnosis been communicated to your patient? ☐ Yes ☐ No

Is this condition related to: ☐ Occupational illness/injury ☐ Auto accident ☐ Criminal act

If so, date of event _____
MMM/DD/YYYY

Details _____

Date of first visit for present condition _____ Since first visit, how often have you seen the patient? ☐ Weekly ☐ Bi Weekly ☐ Monthly
MMM/DD/YYYY

Date of most recent visit _____ Date of next visit _____
MMM/DD/YYYY MMM/DD/YYYY

Has your patient ever had a same or similar condition? ☐ Yes ☐ No

Details _____

Date patient ceased work because of current condition _____
MMM/DD/YYYY

Is condition considered chronic? ☐ Yes ☐ No If yes, what precipitated absence from work? _____

Plan Member _____ _____ _____
First Name Initial Last Name

MEDICAL INFORMATION (CONTINUED)

SYMPTOMS

Please describe your patient's current symptoms (including the frequency and duration) that support the diagnosis under the DSM-5 criteria.

Symptom	Frequency	Severity (mild, moderate, severe)

Screening results (example: MMPI-2, PHQ-9, GAD-7 etc) _____

How have your patient's symptoms evolved to date? ☐ Improved ☐ No change ☐ Worsened

TREATMENT

List any dates of hospitalizations: From _____ (MMM/DD/YYYY) To _____ (MMM/DD/YYYY) Name of Institution _____

From _____ (MMM/DD/YYYY) To _____ (MMM/DD/YYYY) Name of Institution _____

MEDICATION(S)

Name of Medication	Initial dosage and date started	Current dosage and date changed, if applicable	Response

THERAPY

Type of Therapy	Treatment Provider	Provider Speciality	Start Date	Frequency of Visits	Next Appointment	Response

SPECIALIST(S)

If you are not the treating specialist, is your patient currently under the care of a specialist? ☐ Yes ☐ No

Name of Specialist	Specialty	Date of Appointment(s)

CONCURRENT PHYSICAL ILLNESS AND/OR INJURY AND TREATMENT DETAILS

Condition	Treatment	Name of Provider	Results/Response	Projected Duration of Treatment	Next Appointment

Plan Member _____ _____ _____
First Name | Initial | Last Name

MEDICAL INFORMATION (CONTINUED)

CLINICAL FINDINGS AND OBSERVATIONS

Are you aware of the duties of your patient's occupation? ☐ Yes ☐ No

Please describe how the condition is impacting the following and to what degree:

	No Impact	Mild	Moderate	Severe
Appearance (Self Care)	☐	☐	☐	☐
Speech	☐	☐	☐	☐
Openness/Clarity of communication	☐	☐	☐	☐
Comprehension of Questions/Instructions	☐	☐	☐	☐
Concentration/Focus	☐	☐	☐	☐
Affect/Mood	☐	☐	☐	☐
Insight/Judgement	☐	☐	☐	☐
Memory	☐	☐	☐	☐
Decision making	☐	☐	☐	☐
Self-criticism	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Energy	☐	☐	☐	☐
Appetite/Weight	☐	☐	☐	☐
Housekeeping	☐	☐	☐	☐
Recreational Activities/Hobbies	☐	☐	☐	☐
Caregiver Activities	☐	☐	☐	☐

Provide observations or comments detailing how the condition is impacting your patient's ability to function _____

_____

COMPLICATING FACTORS

Please indicate all factors that may have contributed to the clinical problem(s) and may complicate your patient's recovery period:

☐ Alcohol/Drug use ☐ Workplace issues ☐ Family/Social issues ☐ Medication side effects ☐ Financial/Legal problems
☐ Pain Perception ☐ Self-harm behaviour ☐ Coping Skills ☐ Physical condition ☐ Personality/Motivation

Please provide details _____

Please describe the supports in place, or planned, to assist with these issues _____

Has any license held by your patient been restricted or revoked as a result of their medical condition(s)? ☐ Yes ☐ No

If yes, as of when? _____ (MMM/DD/YYYY) Type of license? _____

PROGNOSIS AND RECOVERY

Co-operators encourages rehabilitation assistance, job accommodation (modified/part-time duties) to return an employee to the workplace as soon as medically possible. Based on the information provided we will review your patient's rehabilitation potential.

Prognosis for recovery (include timelines) _____

What return to work goals have been discussed with your patient? _____

Under what circumstances could your patient return to work? (e.g. modified duties, gradual return to work, alternate employer etc.) _____

_____

PHYSICIAN ACKNOWLEDGEMENT AND AUTHORIZATION

I acknowledge that the information in this statement will be kept in a disability benefits file with the plan insurer and might be accessible by the patient or third parties to whom access has been granted or those authorized by law. By providing the information I consent to such unedited release by any information contained herein. Medical and health information excludes genetic test results.

Physician's Stamp

Attending Physician _____

Certified Speciality _____ Family Physician ☐ Yes ☐ No

Address _____ _____ _____ _____
Street City Province Postal Code

Telephone (_____) _____ Fax Number (_____) _____

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Physician Signature _____ Date _____
MMM/DD/YYYY

PRIVACY

CO-OPERATORS PRIVACY STATEMENT

At Co-operators, we recognize and respect the importance of privacy. When you apply for insurance or open an account with us, we will ask for your consent to collect, use, keep and share your personal information. We will explain what information we need, what we will use it for and who we will share it with. We will open a confidential file to collect, use, keep and share your personal information for the purposes of confirming your identity, reviewing your insurance needs and determining suitability of our products and services for you, assessing your application for insurance, issuing and administering your policy, including assessing and processing claims, administering your investments, meeting our contractual and regulatory obligations, detecting and preventing fraud, and performing business and statistical analysis. We will not share your personal information for other purposes, except with your consent or as required or permitted by law.

We may tell you about products and services that may be of interest to you. You can tell us what information you want to receive from us and you can withdraw your consent at any time. You may access and correct, if needed, the personal information in your file by sending us a request in writing.

We limit access to your personal information to our staff and other people we have authorized who need to use it to perform their duties. This may include our third-party service providers who may use your personal information for processing, storage, analysis and disaster recovery purposes outside of your province of residence or Canada. They could be required by law to give your personal information to courts, governments or regulators outside of Canada. To protect your personal information, we ensure that privacy and security requirements are included in all third-party service provider contracts.

You can find more details about our revised privacy policy at www.cooperators.ca/privacy. If you have any questions regarding our privacy policies or about how we collect, use, keep and share your personal information, please contact our Privacy Officer at Co-operators at 1-888-887-7773, or by e-mail: privacy@cooperators.ca.