

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

The completed form can be returned by email, fax, or the original can be mailed to the address provided.

PLAN MEMBER INFORMATION

 Plan Member _____
First Name Initial Last Name

Group _____ Account _____ Certificate _____

Occupation _____

TREATMENT PROVIDER INFORMATION

Co-operators Life Insurance Company ("Co-operators") is committed to supporting its members to maintain their health, and to recover from illness and/ or injury when it occurs. Co-operators strives to enable members to remain-at-work and return-to-work as soon as it is medically appropriate, by accommodating their needs. Your assistance is requested to facilitate this process.

This Functional Abilities form will assist in providing a tailored work program for Co-operators' members. Please complete this form to the best of your ability.

Please do not include any diagnostic or treatment information (including medication).

If there are charges for the completion of the form, please provide your patient with a paid in full receipt.

Co-operators will reimburse the member for professional fees associated with the completion of this form, which do not exceed those suggested by the provincial medical association for this type of service.

GENERAL INFORMATION

 Date you attended to the member _____
MMM/DD/YYYY

 Is the medical condition work-related? Yes No Has a treatment plan been recommended or prescribed? Yes No

 Could the current treatment or medication(s) impede the member's safe performance of his/ her job? Yes No

If yes, please provide details _____

On the basis of your examination, the member may:

- Perform his/ her job to the fullest capacity
- Perform his/ her job based on abilities outlined in the Functional Abilities section
- Not be fit to perform his/ her job

 Date the member will be reassessed _____
MMM/DD/YYYY
FUNCTIONAL ABILITIES

Physical	Full Abilities 8 hours	Frequent Up to 5.5 hours	Occasional Up to 2.5 hours	Seldom Up to 30 min	Restricted No Activity
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending/Twisting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Squatting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing (stairs, ladders)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching Overhead	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crouching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crawling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kneeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Driving	<input type="checkbox"/> Able <input type="checkbox"/> Unable If unable, please explain _____				

TREATMENT PROVIDER INFORMATION (CONTINUED)

Manual Dexterity	<input type="checkbox"/> Fine <input type="checkbox"/> Gross <input type="checkbox"/> Repetitive				
Pushing/Pulling Weight Restrictions	0-20 lbs <input type="checkbox"/> Left <input type="checkbox"/> Right	21-35 lbs <input type="checkbox"/> Left <input type="checkbox"/> Right	36-50 lbs <input type="checkbox"/> Left <input type="checkbox"/> Right	51-100 lbs <input type="checkbox"/> Left <input type="checkbox"/> Right	
Lifting Weight Restrictions	0-20 lbs <input type="checkbox"/> Left <input type="checkbox"/> Right	21-35 lbs <input type="checkbox"/> Left <input type="checkbox"/> Right	36-50 lbs <input type="checkbox"/> Left <input type="checkbox"/> Right	51-100 lbs <input type="checkbox"/> Left <input type="checkbox"/> Right	
Left Hand Strength	<input type="checkbox"/> Full range of motion & normal muscle resistance	<input type="checkbox"/> Full range of motion & reduced muscle resistance	<input type="checkbox"/> Full range of motion & no muscle resistance	<input type="checkbox"/> Reduced range of motion & no muscle resistance	<input type="checkbox"/> No range of motion & palpable muscle contraction only
Right Hand Strength	<input type="checkbox"/> Full range of motion & normal muscle resistance	<input type="checkbox"/> Full range of motion & reduced muscle resistance	<input type="checkbox"/> Full range of motion & no muscle resistance	<input type="checkbox"/> Reduced range of motion & no muscle resistance	<input type="checkbox"/> No range of motion & palpable muscle contraction only

Cognitive	Full Abilities 8 hours	Frequent Up to 5.5 hours	Occasional Up to 2.5 hours	Seldom Up to 30 min	Restricted No Activity
Alertness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Concentration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Memory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Judgement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Multiple tasks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Critical Decision-making	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise sound judgement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Problem solve with speed/accuracy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Interpersonal contact	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Operate motorized equipment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exposure to heat/cold	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exposure to dust/fumes/odors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exposure to chemical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Restrictions are to apply from _____ to _____
MMM/DD/YYYY MMM/DD/YYYY

Full Hours _____ Graduated Hours _____ per day per week

ADDITIONAL COMMENTS

Please provide necessary details about any restriction or limitation you have identified or others that have been missed from the list above.

AUTHORIZATION

I hereby declare that the answers to the above questions are accurate and complete.

Form completed by _____ Treatment Provider Name _____

Title _____ Licence Number _____

Treatment Provider Signature _____ Date _____
MMM/DD/YYYY

Authorized Signaire _____ Date _____
MMM/DD/YYYY

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 privacy policy and how to contact our Privacy Officer at www.cooperators.ca/privacy.