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GROUP BENEFITS ATTENDANCE SUPPORT PROGRAM ATTENDING PHYSICIAN STATEMENT

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

To avoid delays, please complete the required information.

The plan member is responsible for any charge for completing this form or for providing related medical information.

Medical Information is to be completed by the physician providing treatment

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

PLAN MEMBER INFORMATION & AUTHORIZATION (TO BE COMPLETED BY THE PLAN MEMBER)

Plan Member _____ _____ _____
First Name Initial Last Name

Group _____ Account _____ Certificate _____

Plan Sponsor/Employer Name _____ Telephone Number (_____) _____

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

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

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 include copies of chart notes, test results and consultation reports for the past year with this completed form.

Were you aware of your patient's frequent absences from work? ☐ Yes ☐ No

If yes, did your patient provide documentation of the days absent from work? ☐ Yes ☐ No

Does your patient have an ongoing medical condition that impacts their ability to attend work consistently? ☐ Yes ☐ No

Primary Diagnosis _____

Secondary Diagnosis _____

Date symptoms first appeared _____ Date of first visit for present condition _____
MMM/DD/YYYY MMM/DD/YYYY

Is condition considered chronic? ☐ Yes ☐ No

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

RESTRICTIONS AND LIMITATIONS

Please describe the patient's current restriction and limitations that affects their ability to attend work consistently _____

_____

Please provide any social or other non-medical factors that may impact the patient's ability to attend work regularly _____

_____

Plan Member _____ _____ _____
First Name Initial Last Name

MEDICAL INFORMATION (CONTINUED)

TREATMENT (Drug*, Physiotherapy, Other)

*For prescriptions, please provide current dose, date initiated and changed (if applicable) _____

_____

Treatment Providers	Speciality	Dates of Examinations
		_____ MMM/DD/YYYY
		_____ MMM/DD/YYYY
		_____ MMM/DD/YYYY
		_____ MMM/DD/YYYY

HOSPITALIZATION

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 _____

Are any further referrals, investigations and/or treatment pending/planned? ☐ Yes ☐ No

If yes, state type and when _____

Is patient following recommended treatment program? ☐ Yes ☐ No

If no, please explain _____

PROGNOSIS

Based on this patient's medical condition(s), is attendance expected to improve in the foreseeable future? ☐ Yes ☐ No

If yes, please provide estimated time frame for improvement _____

If no, please explain _____

ADDITIONAL COMMENTS

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.

Attending Physician _____

Certified Speciality _____

Address _____ Street _____ City _____ Province _____ Postal Code

Phone Number (_____) _____ Fax Number (_____) _____

Physician Signature _____ Date _____ MMM/DD/YYYY

Physician's Stamp

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.

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