the co-operators®
A Better Place For You®

GROUP BENEFITS
CRITICAL ILLNESS - PHYSICIAN STATEMENT
CORONARY ANGIOPLASTY

MAILING ADDRESS

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

Phone: 1-866-442-3098

Fax: 1-866-889-9925

INSTRUCTIONS

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 specialist.

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 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 PERFORMED (IE. ECG TRACINGS OR PRE-OPERATIVE ANGIOGRAPHY), DIAGNOSTICS, CONSULTATION REPORTS, SURGICAL OR PATHOLOGY REPORTS AND HOSPITALIZATION SUMMARIES.**

2. Indicate your diagnosis for this patient:

_____

_____

_____

3. What type of surgery is required for this patient?

_____

_____

_____

4. Have there been symptoms that led to the recommendation of this surgery? ☐ Yes ☐ No

If yes, please describe the symptoms, severity and onset date:

Symptom	Onset Date	Severity
	_____ (MMM/DD/YYYY)	
	_____ (MMM/DD/YYYY)	
	_____ (MMM/DD/YYYY)	

5. Indicate the tests or procedures used to diagnose this patient's pre-surgical condition:

_____

_____

_____

6. Date you were first consulted for this condition _____ (MMM/DD/YYYY)

7. Date of Diagnosis _____ (MMM/DD/YYYY)

8. Date Patient was Advised of Diagnosis _____ (MMM/DD/YYYY)

9. What type of surgery has been performed and when? (Ie. If coronary artery bypass grafting, please state the number of sites and grafts.)

_____

_____

_____

2. MEDICAL INFORMATION (CONTINUED)

10. Please provide details of the post-surgical treatment protocol:

11. Please provide the address of the hospital where the operation took place and also the name of the surgeon; together with the names of any other consultants involved with your patient's treatment:

12. To the best of your knowledge, has this patient had any history of high blood pressure, high cholesterol, chest pain, diabetes or other pre-cursors for heart disease? ☐ Yes ☐ No

    If yes, please provide details and dates:

13. Is there any record of related illnesses in the patient's family history? ☐ Yes ☐ No

    If yes, please provide details:

14. 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:

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 are 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.

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

Co-operators Life Insurance Company uses reasonable safeguards to protect all information it collects, uses, retains and discloses in the course of conducting business. However, the internet is not a secure medium and we do not use email encryption. As such, we cannot guarantee complete privacy and confidentiality of any email transmissions. This includes the email text and any attachments. By authorizing communication by email, you are acknowledging that you have read and understood this notice and disclaimer and are consenting to the transmission of your personal information using email knowing the email and any attachments may be subject to unauthorized access, use or disclosure by third parties. You agree that Co-operators Life Insurance Company is not responsible or liable for any damages or losses you or any other person may suffer as a result of any breach of privacy, confidentiality or security by transmission of your personal information using email communication. If you no longer wish to communicate with Co-operators Life Insurance Company by email, please send notification to Group_life_claims@cooperators.ca.

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 _____ _____ _____
First Name Initial Last Name

Specialty _____

Physician's Stamp

Address _____ _____ _____ _____
Street City Province Postal Code

Telephone Number (_____) _____ Fax Number (_____)_____

Physician Signature _____ Date _____
MMM/DD/YYYY

Co-operators Life Insurance Company Privacy Statement

At The 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 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 The Co-operators privacy policy at www.cooperators.ca. 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 The Co-operators at 1-888-887-7773, or by e-mail: privacy@cooperators.ca