

MAILING ADDRESS

Mail: Co-operators Life Insurance Company
Group Life Claims Department
1920 College Avenue
Regina SK S4P 1C4
Fax: 1-866-889-9925

INSTRUCTIONS

The plan member is responsible for the cost of completing this form.
Medical Information is to be completed by the physician providing treatment.

1. 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 _____
MMM/DD/YYYY

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.

Plan Member Signature _____ Date _____
MMM/DD/YYYY

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

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

DIAGNOSIS

Primary Diagnosis _____ Secondary Diagnosis _____

Other contributing factors/complications _____

Date Diagnosed _____ By whom _____
MMM/DD/YYYY

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

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

Has patient ever had same or similar condition? Yes No
If yes, provide date and details _____

What limitations and restrictions is your patient experiencing as a result of the diagnosis? _____

Investigations (e.g. EKG's, x-rays, lab tests, etc.)	Date Carried Out	Summary of Results (attach copies of all available reports)

Are any further investigations planned? Yes No If yes, state type and when _____

TREATMENT

Name of Medication	Dosage	Dated Initiated	Reason for change in medication, if applicable

Treatment Providers	Provider Speciality	Dates of Examinations

Are any further referrals pending/planned? Yes No Provide details _____

Summarize patient's response to treatment _____

3. 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.

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.

Attending Physician (Please Print) _____

Address _____
Street City Province Postal Code

Certified Speciality _____ Family Physician Yes No

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

Physician Signature _____ Date _____
MMM/DD/YYYY

Physician's Stamp

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.