the co-operators®
A Better Place For You®

GROUP BENEFITS
CRITICAL DISEASE PHYSICIAN STATEMENT

FOR OFFICE USE ONLY

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 _____

(SEE REVERSE)

Plan Member _____ _____ _____
First Name Initial Last Name

FOR OFFICE USE ONLY

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.

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.