the co-operators®
A Better Place For You®

GROUP BENEFITS
CRITICAL ILLNESS - PHYSICIAN STATEMENT
AUTISM

MAILING ADDRESS	INSTRUCTIONS
Mail: Co-operators Life Insurance Company Life Claims Department 1920 College Avenue Regina SK S4P 1C4 Phone: 1-866-442-3098 Fax: 1-866-889-9925	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 physician. The Patient's parent/legal guardian 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 _____ _____ _____ Date of Birth _____
First Name Initial Last Name 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 (INCLUDING MODIFIED CHECKLIST FOR AUTISM IN TODDLERS (M-CHAT), AUTISM DIAGNOSTIC INTERVIEW-REVISED (ADI-R), AUTISM DIAGNOSTIC OBSERVATION SCALE (ADOS)), MEDICAL OR NEUROLOGICAL INVESTIGATIONS, INTERVIEWS, OBSERVATION AND EVALUATIONS, AS WELL AS CONSULTATION REPORTS AND HOSPITALIZATION SUMMARIES.**

2. Indicate your diagnosis for this patient:

☐ Autism Diagnosis Date _____ MMM/DD/YYYY

☐ Asperger Syndrome Diagnosis Date _____ MMM/DD/YYYY

☐ Autism Spectrum Disorder Diagnosis Date _____ MMM/DD/YYYY

☐ Pervasive Developmental Disorder Diagnosis Date _____ MMM/DD/YYYY

☐ Undetermined Diagnosis Date _____ MMM/DD/YYYY

☐ Other _____ Diagnosis Date _____ MMM/DD/YYYY

3. Date this diagnosis was first discussed with the parent/guardian of this patient _____ MMM/DD/YYYY

4. Are you the patient's usual physician? ☐ Yes ☐ No

If no, please provide the full name and address of this patient's usual physician: _____

_____

5. Please list the symptoms that led to consultation with you regarding this illness. Please state the onset date and the severity of each symptom:

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

6. What was earliest age that the child's symptoms became suspicious for Autism, as indicated by a Specialist (Psychologist, Developmental Pediatrician, Pediatric Neurologist):

_____

2. MEDICAL INFORMATION (CONTINUED)

7. Please check the triggers/behaviors listed below that led to the referral to the Specialist (Psychologist, Developmental Pediatrician or Pediatric Neurologist):

SOCIAL

- ☐ Marked impairment in the use of multiple nonverbal behaviors, such as eye-to-eye gaze, facial expression, body postures and gestures, to regulate social interaction
- ☐ Failure to develop peer relationships appropriate to developmental level
- ☐ Lack of spontaneous seeking to share enjoyment, interests, or achievements with other people (e.g. by lack of showing, bringing or pointing out objects of interest)
- ☐ Lack of social or emotional reciprocity

COMMUNICATION

- ☐ Delay in, or lack of, the development of spoken language

MOTOR

- ☐ Stereotyped and repetitive motor mannerisms (e.g. hand or finger flapping or twisting, or complex whole body movements)

OTHER

- ☐ Symbolic or imaginative play
- ☐ Restrictive repetitive and stereotypic patterns of behavior, interests, and activities
- ☐ Other: _____

8. Date you were first consulted regarding this illness _____
MMM/DD/YYYY

9. What tests were conducted to make this diagnosis? _____

10. Please provide details of the current treatment received, including details and dates of any hospital investigations or in-patient treatment:

11. Has there been a referral to any treatment facility, specialized medical facility or care provider for on-going care? ☐ Yes ☐ No
If yes, please provide details including dates(s) and location(s):

12. Have any blood relatives suffered from a similar or related illness? ☐ Yes ☐ No
If yes, state relationship of relative, nature of illness and the age at which the illness was diagnosed:

13. Is there any record of illnesses or contributory conditions (e.g. prenatal injury, injury at birth, hypoxia, mitochondrial disorder, genetic disorders, other) in the child's medical history or in the child's family history:

14. Please provide the name and address of all consultants, specialists or hospitals to which your patient has been referred or attended for this condition (include dates and reasons attended):

15. 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.

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

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.