

# GROUP BENEFITS CRITICAL ILLNESS - PHYSICIAN STATEMENT BURNS

MAILING ADDRESS	INSTRUCTIONS
<p>Mail: Co-operators Life Insurance Company Life Claims Department 1920 College Avenue Regina SK S4P 1C4</p> <p>Phone: 1-866-442-3098</p> <p>Fax: 1-866-889-9925</p>	<p>Please print clearly and be sure all sections are complete to avoid delays in processing the claim.</p> <p>The confidential Medical Information section is to be completed by your physician.</p> <p>The Patient is responsible for the cost of completing this form.</p> <p>Condition(s) listed above may or may not be covered under your Policy. <b>Please refer to your Group Contract to confirm coverage for the condition claimed.</b></p> <p><b>The completed form must be faxed directly from the Physician's office or the original can be mailed to the address provided.</b></p>

**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, DIAGNOSTICS, CONSULTATION REPORTS AND HOSPITALIZATION SUMMARIES.**

2. Please comment on the location, degree, severity and the percentage of the body surface covered by the burns:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

3. Date of the Incident \_\_\_\_\_  
MMM/DD/YYYY

4. Are you aware of the details of the event resulting in your patient's condition?  Yes  No

If yes, please provide details, including the type of burn (chemical, fire, steam etc.):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

6. Is there any indication of depression or suicide in the patient's medical history?  Yes  No

If yes, please provide dates and details below:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

7. Did this condition result from any employment/environmental factors or other condition OR did the incident result from ingestion of drugs (prescribed or not prescribed), alcohol, mental-nervous condition, intravenously introduced substance or self-inflicted injury?  Yes  No

If yes, please provide details:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## 2. MEDICAL INFORMATION (CONTINUED)

8. 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:

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9. 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

10. Please provide the name and address of all consultants, specialists or hospitals to which your patient has been referred or attended for this condition:

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11. Please describe the treatment protocol:

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12. Please provide any information you feel would be relevant to our review of your patient's claim for benefits:

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## 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](mailto: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 \_\_\_\_\_

Address \_\_\_\_\_  
Street City Province Postal Code

Telephone 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.