the co-operators
A Better Place For You®

GROUP BENEFITS
CRITICAL ILLNESS - PHYSICIAN STATEMENT
CYSTIC FIBROSIS

MAILING ADDRESS

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

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 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 _____ (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 (INCLUDING CT SCAN, CHEST X-RAY, ECG OR EKG, MRI), LAB WORK, DIAGNOSTICS, CONSULTATION REPORTS AND HOSPITALIZATION SUMMARIES.**

2. Indicate the diagnosis for this patient:

_____

_____

_____

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

4. Was this diagnosis made by a Pediatric Respirologist in Canada? ☐ Yes ☐ No

   Please provide name of physician: _____

5. Date the diagnosis or possible diagnosis of Cystic Fibrosis was first discussed with the parent/guardian of this patient _____ (MMM/DD/YYYY)

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

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

_____

_____

_____

7. Date when any of the following typical symptoms first appeared:

   ☐ Difficulty Breathing/Respiratory Tract Problems _____ (MMM/DD/YYYY)

   ☐ Sever, Chronic Lung Infections _____ (MMM/DD/YYYY)

   ☐ Failure to Grow or Gain Weight _____ (MMM/DD/YYYY)

   ☐ Extreme Difficulty Digesting Food _____ (MMM/DD/YYYY)

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

2. MEDICAL INFORMATION (CONTINUED)

9. What tests were conducted to arrive at this diagnosis, and the dates of those tests?

☐ Sweat Test _____ MMM/DD/YYYY

☐ Immunoreactive Trypsinogen Test (IRT) _____ MMM/DD/YYYY

☐ Other _____ _____ MMM/DD/YYYY

10. Have all other possible conditions been ruled out (ie. Asthma, chronic bronchitis, pneumonia or celiac disease)? ☐ Yes ☐ No

11. Please describe the current clinical presentation and treatment protocol:

_____

_____

_____

12. 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 date(s) and location(s):

_____

_____

_____

13. Has the patient previously suffered from, or received treatment for, a similar or related illness? ☐ Yes ☐ No

If yes, please provide dates and details:

_____

_____

_____

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

If yes, state relationship of relative, nature of illness and the age at which the illness was diagnosed:

_____

_____

_____

15. Please provide details of anything in the patient's personal medical history (including prenatal and birth) or family history which would have increased the risk or contributed to his/her condition:

_____

_____

_____

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.

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

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