

GROUP BENEFITS

CRITICAL ILLNESS - PHYSICIAN STATEMENT LOSS OF INDEPENDENT EXISTENCE

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 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, DIAGNOSTICS, CONSULTATION REPORTS AND HOSPITALIZATION SUMMARIES.

2. Please state the patient's:

Primary Diagnosis _____ Onset of symptoms _____
(MMM/DD/YYYY)

Secondary Diagnosis _____ Onset of symptoms _____
(MMM/DD/YYYY)

3. Date the Patient was Advised of Diagnosis _____
(MMM/DD/YYYY)

4. Date the patient first consulted you _____
(MMM/DD/YYYY)

5. What were the symptoms experienced by the patient?

6. Was there a trigger for this diagnosis (i.e. accident, suicide attempt, drugs, alcohol, etc.)?

7. Please indicate the degree of assistance required by the patient to perform the Activity of Daily Living described. Check off only one box for each of these activities to specify the patient's current capacity level.

Bathing - the ability to wash oneself in a bathtub, shower or by sponge bath, with or without the aid of equipment.
Dressing - the ability to put on and remove necessary clothing including braces, artificial limbs or other surgical appliances.
Toileting - the ability to get to and from the toilet and maintain personal hygiene.
Bladder and Bowel Continence - the ability to manage bowel and bladder function with or without protective undergarments or surgical appliances so that a reasonable level of hygiene is maintained.
Transferring - the ability to move in and out of a bed, chair or wheelchair, with or without the use of equipment.
Feeding - the ability to consume food that has already been prepared and made available, with or without the use of adaptive utensils.

Activity of Daily Living	Patient requires no assistance and performs the ADL independently	Patient requires some assistance each time he/she performs the ADL	Patient requires direct physical assistance of another person to perform the ADL	On what date did the patient first require assistance (MMM/DD/YYYY)
Bathing				
Dressing				
Toileting				
Bladder/Bowel Continence				
Transferring				
Feeding				

2. MEDICAL INFORMATION (CONTINUED)

8. Please describe the patient's ability to perform these activities:

9. Has the patient been diagnosed with a cognitive impairment? Yes No

If yes, please provide the diagnosis: _____

Date of onset _____
(MMM/DD/YYYY)

Diagnostic tests performed _____

10. Check one of the following to specify the patient's degree of cognitive impairment:

- The patient does not have any cognitive impairment
- The patient has mild cognitive impairment
- The patient has a serious cognitive impairment (he/she requires constant supervision as well as reminders to protect his/her health and safety)

11. Is there any record of related illnesses in the patient's family history, or any other related family history? Yes No

If yes, please provide details:

12. Please give 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:

13. 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)

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:

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