the co-operators®
A Better Place For You®

GROUP BENEFITS
CRITICAL ILLNESS - PHYSICIAN STATEMENT
LOSS OF INDEPENDENT EXISTENCE

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 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, 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:

_____

_____

_____

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.