

GROUP BENEFITS CRITICAL ILLNESS - PHYSICIAN STATEMENT LOSS OF SPEECH

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. Please refer to your Contract to confirm coverage for the condition claimed.</p> <p>The completed form must be faxed directly from the Physician's office or the original can be mailed to the address provided.</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, CONSULTATION REPORTS AND HOSPITALIZATION SUMMARIES.

2. Indicate your diagnosis for this patient:

3. This condition is the result of:

Accident

Please provide dates and details:

Disease

Please provide dates and details:

Degenerative Process

Please provide dates and details:

4. Date of Diagnosis _____
MMM/DD/YYYY

5. What tests or procedures were conducted to make the diagnosis?

2. MEDICAL INFORMATION (CONTINUED)

6. Date Patient was Advised of Diagnosis _____
MMM/DD/YYYY

7. What treatment has been undertaken for this condition?

8. What is your prognosis for this patient with respect to:
a) Partial recovery of speech

b) Full recovery of speech

9. 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:

10. Did this condition result from any other factors such as a stroke, tumour, cancer or other condition OR did the incident/surgery result from ingestion of drugs (prescribed or not prescribed), alcohol, intravenously introduced substance, mental-nervous condition or self-inflicted injury? Yes No
If yes, please provide details:

11. 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:

12. 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

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

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

