

GROUP BENEFITS

CRITICAL ILLNESS - PHYSICIAN STATEMENT

MUSCULAR DYSTROPHY

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's parent/legal guardian 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 (INCLUDING ELECTROMYOGRAPHY AND MUSCLE BIOPSY), DIAGNOSTICS, CONSULTATION REPORTS AND HOSPITALIZATION SUMMARIES.

2. Indicate the diagnosis for this patient:

3. Date of Diagnosis _____
MMM/DD/YYYY

4. Date the diagnosis of or possible diagnosis of Muscular Dystrophy was first discussed with the parent/guardian of this patient _____
MMM/DD/YYYY

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

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

6. Please list the symptoms that led to consultation with you regarding this illness. Please state the onset date and severity of each symptom:

Symptom	Onset Date	Severity

	<small>MMM/DD/YYYY</small>	

	<small>MMM/DD/YYYY</small>	

	<small>MMM/DD/YYYY</small>	

	<small>MMM/DD/YYYY</small>	

	<small>MMM/DD/YYYY</small>	

7. Date you were first consulted regarding this illness _____
MMM/DD/YYYY

8. What tests were conducted to make this diagnosis?

2. MEDICAL INFORMATION (CONTINUED)

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

10. 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):

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

If yes, please provide dates and details:

12. 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:

13. 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:

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.

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.

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.