the co-operators®
A Better Place For You®

GROUP BENEFITS
CRITICAL ILLNESS - PHYSICIAN STATEMENT
OCCUPATIONAL HIV INFECTION

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 Group 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 OFFICE RECORDS, INVESTIGATIONS/TESTS PERFORMED, CONSULTATION REPORTS AND HOSPITAL SUMMARIES.

2. Date of incident which exposed the patient to contaminated body fluids? _____ (MMM/DD/YYYY)

3. Please provide full details of the method of transmission, and where the incident occurred:

_____

_____

_____

4. Was an incident report completed by the Employer? ☐ Yes ☐ No

5. Do you know whether the incident was witnessed? ☐ Yes ☐ No

6. Date the patient first consulted you regarding this incident _____ (MMM/DD/YYYY)

7. How long has this person been your patient? _____

8. 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:

_____

_____

_____

9. Please provide dates and results of all HIV or antibody tests performed:

Date (MMM/DD/YYYY)	**Results**

10. Date patient was first diagnosed as HIV positive _____ (MMM/DD/YYYY)

11. Date patient was first advised of the diagnosis _____ (MMM/DD/YYYY)

12. Who advised the patient of the diagnosis? _____

_____

13. Had the patient taken any available licensed vaccine offering prevention against HIV? ☐ Yes ☐ No

If yes, please provide date: _____ (MMM/DD/YYYY)

2. MEDICAL INFORMATION (CONTINUED)

14. Was the incident reported in accordance with Canadian workplace guidelines? ☐ Yes ☐ No

If no, please provide details:

_____

_____

_____

15. 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 used or were used per day? _____ Date last used _____ (MMM/DD/YYYY)

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.

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's Stamp

Physician _____ _____ _____
First Name Initial Last Name

Specialty _____

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.