

GROUP BENEFITS CRITICAL ILLNESS - PHYSICIAN STATEMENT PARKINSON'S DISEASE

MAILING ADDRESS	INSTRUCTIONS
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<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 neurologist.</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 Group 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>
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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/TESTS PERFORMED, CONSULTATION REPORTS AND ALL HOSPITALIZATION SUMMARIES.

2. Date Symptoms Began _____
MMM/DD/YYYY

3. Please describe the symptoms:

4. Date patient first consulted you for these symptoms _____
MMM/DD/YYYY

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

6. Date the diagnosis of possible Parkinson's Disease was first discussed with the patient _____
MMM/DD/YYYY

7. Date the diagnosis was confirmed _____
MMM/DD/YYYY

8. Is the diagnosis Primary Idiopathic Parkinson's Disease? Yes No

If yes, please provide the name and address of the specialist who confirmed the diagnosis:

9. Please outline the clinical course and describe the patient's neurological signs and symptoms, providing dates and duration:

2. MEDICAL INFORMATION (CONTINUED)

10. 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 & 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 each time he/she performs the ADL	On what date did the patient first require assistance (MMM/DD/YYYY)
Bathing				
Dressing				
Toileting				
Bladder/Bowel Continence				
Transferring				
Eating				

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

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

13. Has the patient previously suffered from any predisposing disorders? Yes No

If yes, please provide details:

14. a) Is there a family history of Parkinson's Disease? Yes No

If yes, please provide details:

2. MEDICAL INFORMATION (CONTINUED)

14. b) Is there any other significant family history? Yes No

If yes, please provide details:

15. 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:

16. 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

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 _____
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.