the co-operators
A Better Place For You®

GROUP BENEFITS
CRITICAL ILLNESS - PHYSICIAN STATEMENT
STROKE OR CEREBROVASCULAR ACCIDENT (CVA)

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 neurologist.

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 _____ (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. Indicate your diagnosis for this patient:

   _____

   _____

   _____

3. Date Symptoms Began _____ (MMM/DD/YYYY)
4. Date of Diagnosis _____ (MMM/DD/YYYY)
5. Date Patient was Advised of Diagnosis _____ (MMM/DD/YYYY)
6. 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:

   _____

   _____

   _____

7. 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:

   _____

   _____

   _____

8. 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)

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

   _____

   _____

   _____

2. MEDICAL INFORMATION (CONTINUED)

10. Please describe the initial episode - nature of episode, date and duration of acute symptoms:

_____

_____

_____

11. Date of return to normal activities and/or the patient's current limitations (physical and mental). Comment on neurological sequelae which lasted more than 30 days. Are these sequelae permanent?

_____

_____

_____

12. Has there been an infarction of brain tissue, hemorrhage or embolization from an extra-cranial source? ☐ Yes ☐ No

If yes, please provide details:

_____

_____

_____

13. 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.