the co-operators®
A Better Place For You®

GROUP BENEFITS
CRITICAL ILLNESS - PHYSICIAN STATEMENT
TYPE 1 DIABETES MELLITUS

MAILING ADDRESS	INSTRUCTIONS
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	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's parent/legal guardian 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 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, LAB WORK, CONSULTATION REPORTS AND HOSPITALIZATION SUMMARIES.**

2. Indicate the diagnosis for this patient:

_____

_____

_____

3. Date of Diagnosis _____ (MMM/DD/YYYY)

4. Was this diagnosis made by a Pediatric Endocrinologist in Canada? ☐ Yes ☐ No

   Please provide name of physician: _____

5. Date the diagnosis or possible diagnosis of Type 1 Diabetes Mellitus was first discussed with the parent/guardian of this patient _____ (MMM/DD/YYYY)

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

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

_____

_____

_____

7. Date when any of the following typical symptoms first appeared:

   ☐ Extreme Thirst and Hunger _____ (MMM/DD/YYYY)

   ☐ Frequent Need to Urinate _____ (MMM/DD/YYYY)

   ☐ Unintentional Weight Loss or Failure to Grow or Gain Weight _____ (MMM/DD/YYYY)

   ☐ Unusual Fatigue _____ (MMM/DD/YYYY)

   ☐ Vision Deterioration _____ (MMM/DD/YYYY)

   ☐ Confusion and/or Unconsciousness _____ (MMM/DD/YYYY)

8. Date you were first consulted regarding this illness _____ (MMM/DD/YYYY)

9. What tests were conducted to make this diagnosis?

_____

_____

_____

2. MEDICAL INFORMATION (CONTINUED)

10. Date patient began treatment with Insulin _____
MMM/DD/YYYY

11. Pease describe the patient's current Insulin dosage and regimen:

_____

_____

_____

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.

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.