co-operators
Investments. Insurance. Advice.

GROUP BENEFITS CRITICAL DISEASE PHYSICIAN STATEMENT

CONTACT INFORMATION

Mail: Co-operators Life Insurance Company
Group Life Claims Department
1900 Albert Street
Regina SK S4P 4K8

Phone: 1-866-442-3098
Fax: 1-866-889-9925
Email: group_life_claims@cooperators.ca

INSTRUCTIONS

The plan member is responsible for the cost of completing this form.

Medical Information is to be completed by the physician providing treatment.

The completed form must be emailed or faxed to Co-operators directly from the Physician's office, or the original can be mailed to the address provided.

1. PLAN MEMBER INFORMATION & AUTHORIZATION (TO BE COMPLETED BY THE PLAN MEMBER)

Plan Member ____________________ ______ ____________________
First Name Initial Last Name

Group ____________________ Account ____________________ Certificate ____________________

Plan Sponsor/Employer Name ____________________ Telephone Number (_______) ____________________

Date of Birth ____________________
MMM/DD/YYYY

I hereby authorize my physician to release any medical information supporting my claim for disability benefits to the plan administrator, the plan adjudicator and my insurer. I understand that I am responsible for obtaining this form and for any amounts charged by my physician to complete this form.

Plan Member Signature ____________________ Date ____________________
MMM/DD/YYYY

2. MEDICAL INFORMATION (TO BE COMPLETED BY THE PHYSICIAN)

Please attach copies of chart notes, test results, and consultation reports.

DIAGNOSIS

Primary Diagnosis ____________________ Secondary Diagnosis ____________________

Other contributing factors/complications ____________________

Date Diagnosed ____________________ By whom ____________________
MMM/DD/YYYY

Date symptoms first appeared ____________________ Date of first visit for present condition ____________________
MMM/DD/YYYY MMM/DD/YYYY

Date patient ceased work because of present condition ____________________
MMM/DD/YYYY

Has patient ever had same or similar condition? ☐ Yes ☐ No

If yes, provide date and details ____________________

What limitations and restrictions is your patient experiencing as a result of the diagnosis? ____________________

Investigations (e.g. EKG's, x-rays, lab tests, etc.)	Date Carried Out	Summary of Results (attach copies of all available reports)

Are any further investigations planned? ☐ Yes ☐ No If yes, state type and when ____________________

TREATMENT

Name of Medication	Dosage	Dated Initiated	Reason for change in medication, if applicable

Treatment Providers	Provider Speciality	Dates of Examinations

Are any further referrals pending/planned? ☐ Yes ☐ No Provide details ____________________

Summarize patient's response to treatment ____________________

Co-operators® is a registered trademark of The Co-operators Group Limited

Plan Member ______________________ ______ ______________________
First Name Initial Last Name

3. PHYSICIAN ACKNOWLEDGEMENT AND AUTHORIZATION

I acknowledge that the information in this statement will be kept in a disability benefits file with the plan insurer and might be accessible by the patient or third parties to whom access has been granted or those authorized by law. By providing the information I consent to such unedited release by any information contained herein.

If you would like Co-operators to communicate with you by email about this claim, please provide your email ______________________

You acknowledge that data transmitted over the internet may be intercepted and that such transmission is at your own risk. If you no longer wish to communicate with Co-operators Life Insurance Company by email, please send notification to group_life_claims@cooperators.ca.

Attending Physician (Please Print) ______________________

Address ______________________ ______________________ ______ ______________________
Street City Province Postal Code

Certified Speciality ______________________ Family Physician ☐ Yes ☐ No

Phone Number (________)______________________ Fax Number (________) ______________________

Physician Signature ______________________ Date ______________________
MMM/DD/YYYY

Physician's Stamp

4. PRIVACY

Co-operators Life Insurance Company Privacy Statement

At Co-operators, we recognize and respect the importance of privacy. When you apply for insurance or open an account with us, we will ask for your consent to collect, use, keep and share your personal information. We will explain what information we need, what we will use it for and who we will share it with. We will open a confidential file to collect, use, keep and share your personal information for the purposes of confirming your identity, reviewing your insurance needs and determining suitability of our products and services for you, assessing your application for insurance, issuing and administering your policy, including assessing and processing claims, administering your investments, meeting our contractual and regulatory obligations, detecting and preventing fraud, and performing business and statistical analysis. We will not share your personal information for other purposes, except with your consent or as required or permitted by law.

We may tell you about products and services that may be of interest to you. You can tell us what information you want to receive from us and you can withdraw your consent at any time. You may access and correct, if needed, the personal information in your file by sending us a request in writing.

We limit access to your personal information to our staff and other people we have authorized who need to use it to perform their duties. This may include our third-party service providers who may use your personal information for processing, storage, analysis and disaster recovery purposes outside of Canada. They could be required by law to give your personal information to courts, governments or regulators outside of Canada. To protect your personal information, we ensure that privacy and security requirements are included in all third-party service provider contracts.

You can find more details about the Co-operators privacy policy at www.cooperators.ca. If you have any questions regarding our privacy policies or about how we collect, use, keep and share your personal information, please contact our Privacy Officer at Co-operators at 1-888-887-7773, or by e-mail: privacy@cooperators.ca

Co-operators® is a registered trademark of The Co-operators Group Limited