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GROUP BENEFITS
CRITICAL ILLNESS - PHYSICIAN STATEMENT
AUTISM

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

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 emailed or faxed to Co-operators 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 (including modified checklist for autism in Toddlers (M-CHAT), Autism Diagnostic Interview-Revised (ADI-R), Autism Diagnostic Observation Scale (ADOS), medical or Neurological investigations, interviews, observation and evaluations, as well as consultation reports and hospitalization summaries.**

2. Indicate your diagnosis for this patient:

☐ Autism Diagnosis Date _____ (MMM/DD/YYYY)

☐ Asperger Syndrome Diagnosis Date _____ (MMM/DD/YYYY)

☐ Autism Spectrum Disorder Diagnosis Date _____ (MMM/DD/YYYY)

☐ Pervasive Developmental Disorder Diagnosis Date _____ (MMM/DD/YYYY)

☐ Undetermined Diagnosis Date _____ (MMM/DD/YYYY)

☐ Other _____ Diagnosis Date _____ (MMM/DD/YYYY)

3. Date this diagnosis was first discussed with the parent/guardian of this patient _____ (MMM/DD/YYYY)

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

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

5. Please list the symptoms that led to consultation with you regarding this illness. Please state the onset date and the severity of each symptom:

Symptom	Onset Date	Severity
	_____ (MMM/DD/YYYY)	
	_____ (MMM/DD/YYYY)	
	_____ (MMM/DD/YYYY)	
	_____ (MMM/DD/YYYY)	
	_____ (MMM/DD/YYYY)	

6. What was earliest age that the child's symptoms became suspicious for Autism, as indicated by a Specialist (Psychologist, Developmental Pediatrician, Pediatric Neurologist):

2. MEDICAL INFORMATION (CONTINUED)

7. Please check the triggers/behaviors listed below that led to the referral to the Specialist (Psychologist, Developmental Pediatrician or Pediatric Neurologist):

SOCIAL

- ☐ Marked impairment in the use of multiple nonverbal behaviors, such as eye-to-eye gaze, facial expression, body postures and gestures, to regulate social interaction
- ☐ Failure to develop peer relationships appropriate to developmental level
- ☐ Lack of spontaneous seeking to share enjoyment, interests, or achievements with other people (e.g. by lack of showing, bringing or pointing out objects of interest)
- ☐ Lack of social or emotional reciprocity

COMMUNICATION

- ☐ Delay in, or lack of, the development of spoken language

MOTOR

- ☐ Stereotyped and repetitive motor mannerisms (e.g. hand or finger flapping or twisting, or complex whole body movements)

OTHER

- ☐ Symbolic or imaginative play
- ☐ Restrictive repetitive and stereotypic patterns of behavior, interests, and activities
- ☐ Other: _____

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

9. What tests were conducted to make this diagnosis? _____

10. Please provide details of the current treatment received, including details and dates of any hospital investigations or in-patient treatment:

11. Has there been a referral to any treatment facility, specialized medical facility or care provider for on-going care? ☐ Yes ☐ No
If yes, please provide details including dates(s) and location(s):

12. Have any blood relatives suffered from a similar or related illness? ☐ Yes ☐ No
If yes, state relationship of relative, nature of illness and the age at which the illness was diagnosed:

13. Is there any record of illnesses or contributory conditions (e.g. prenatal injury, injury at birth, hypoxia, mitochondrial disorder, genetic disorders, other) in the child's medical history or in the child's family history:

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 (include dates and reasons attended):

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.

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.

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

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