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Investments. Insurance. Advice.

GROUP BENEFITS
CRITICAL ILLNESS - PHYSICIAN STATEMENT
CYSTIC FIBROSIS

CONTACT INFORMATION	INSTRUCTIONS
Mail: Co-operators Life Insurance Company Group Life Claims Department 1900 Albert Street Regina SK S4P 4K8	Please print clearly and be sure all sections are complete to avoid delays in processing the claim.
Phone: 1-866-442-3098	The confidential Medical Information section is to be completed by your physician.
Fax: 1-866-889-9925	The Patient's parent/legal guardian is responsible for the cost of completing this form.
Email: group_life_claims@cooperators.ca	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 _____ _____ _____ 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 performed (including CT scan, chest X-ray, ECG or EKG, MRI), lab work, diagnostics, 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 Respirologist in Canada? ☐ Yes ☐ No

   Please provide name of physician:_____
5. Date the diagnosis or possible diagnosis of Cystic Fibrosis 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:

   ☐ Difficulty Breathing/Respiratory Tract Problems _____
   MMM/DD/YYYY

   ☐ Sever, Chronic Lung Infections _____
   MMM/DD/YYYY

   ☐ Failure to Grow or Gain Weight _____
   MMM/DD/YYYY

   ☐ Extreme Difficulty Digesting Food _____
   MMM/DD/YYYY
8. Date you were first consulted regarding this illness _____
MMM/DD/YYYY

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2. MEDICAL INFORMATION (CONTINUED)

9. What tests were conducted to arrive at this diagnosis, and the dates of those tests?

☐ Sweat Test _____ MMM/DD/YYYY

☐ Immunoreactive Trypsinogen Test (IRT) _____ MMM/DD/YYYY

☐ Other _____ _____ MMM/DD/YYYY

10. Have all other possible conditions been ruled out (ie. Asthma, chronic bronchitis, pneumonia or celiac disease)? ☐ Yes ☐ No

11. Please describe the current clinical presentation and treatment protocol:

12. 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 date(s) and location(s):

13. Has the patient previously suffered from, or received treatment for, a similar or related illness? ☐ Yes ☐ No

If yes, please provide dates and details:

14. 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:

15. 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 their condition:

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

17. Please provide any information you feel would be relevant to our review of your patient's claim for benefits:

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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'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

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