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GROUP BENEFITS
CRITICAL ILLNESS - PHYSICIAN STATEMENT
LOSS OF LIMBS

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 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 _____ _____ _____ 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, consultation reports and hospitalization summaries.**

2. Please indicate the current condition of this patient (at home, in a care facility etc.):

3. Please indicate which limbs have been severed, and whether the total or partial limb was removed:

4. Date Incident/Surgery Occurred _____
MMM/DD/YYYY

5. Were limbs lost due to an **accident**? ☐ Yes ☐ No
If yes, please provide details and dates:

6. Were limbs removed due to an **illness**? ☐ Yes ☐ No
If yes, please describe the underlying illness or symptoms prior to the surgery:

When was the condition first diagnosed and by whom? _____

Date Patient was Advised of Diagnosis _____
MMM/DD/YYYY

2. MEDICAL INFORMATION (CONTINUED)

7. Did this condition result from any other factors such as complications of surgery, diabetes or other condition OR did the incident/surgery result from ingestion of drugs (prescribed or not prescribed), alcohol, intravenously introduced substance, mental-nervous condition or self-inflicted injury? ☐ Yes ☐ No

   If yes, please provide details:

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

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

9. Is there any record of any related previous condition or similar illness in the patient's medical history? ☐ Yes ☐ No

   If yes, please provide details:

10. 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:

11. 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 their condition:

12. 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

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

14. 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