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GROUP BENEFITS
CRITICAL ILLNESS - PHYSICIAN STATEMENT
PARKINSON'S DISEASE

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 neurologist.

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 Group 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/tests performed, consultation reports and all hospitalization summaries.**
2. Date Symptoms Began _____
MMM/DD/YYYY
3. Please describe the symptoms:
4. Date patient first consulted you for these symptoms _____
MMM/DD/YYYY
5. How long has this person been your patient? _____
6. Date the diagnosis of possible Parkinson's Disease was first discussed with the patient _____
MMM/DD/YYYY
7. Date the diagnosis was confirmed _____
MMM/DD/YYYY
8. Is the diagnosis Primary Idiopathic Parkinson's Disease? ☐ Yes ☐ No
   If yes, please provide the name and address of the specialist who confirmed the diagnosis:
9. Please outline the clinical course and describe the patient's neurological signs and symptoms, providing dates and duration:

2. MEDICAL INFORMATION (CONTINUED)

10. Please indicate the degree of assistance required by the patient to perform the Activity of Daily Living described. Check off only one box for each of these activities to specify the patient's current capacity level.

BATHING the ability to wash oneself in a bathtub, shower or by sponge bath, with or without the aid of equipment.

DRESSING the ability to put on and remove necessary clothing including braces, artificial limbs or other surgical appliances.

TOILETING the ability to get to and from the toilet and maintain personal hygiene.

BLADDER & BOWEL CONTINENCE the ability to manage bowel and bladder function with or without protective undergarments or surgical appliances so that a reasonable level of hygiene is maintained.

TRANSFERRING the ability to move in and out of a bed, chair or wheelchair, with or without the use of equipment.

FEEDING the ability to consume food that has already been prepared and made available, with or without the use of adaptive utensils.

Activity of Daily Living	Patient requires no assistance and performs the ADL independently	Patient requires some assistance each time they performs the ADL	Patient requires direct physical assistance each time they perform the ADL	On what date did the patient first require assistance (MMM/DD/YYYY)
Bathing				
Dressing				
Toileting				
Bladder/Bowel Continence				
Transferring				
Eating				

11. Please describe the patient's ability to perform these activities.

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

13. Has the patient previously suffered from any predisposing disorders? ☐ Yes ☐ No

If yes, please provide details:

14. a) Is there a family history of Parkinson's Disease? ☐ Yes ☐ No

If yes, please provide details:

2. MEDICAL INFORMATION (CONTINUED)

14. b) Is there any other significant family history? ☐ Yes ☐ No

If yes, please provide details:

15. 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:

16. 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

17. 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

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