the co-operators®
A Better Place For You®

GROUP BENEFITS
LONG TERM DISABILITY
ATTENDING PHYSICIAN STATEMENT

MAILING ADDRESS

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

Fax: 1-866-889-9926

Email: disability_claims_admin@cooperators.ca

INSTRUCTIONS

Important note: Please ensure you complete the appropriate Attending Physician Statement form based on your patient's primary diagnosis. There are two forms, one for mental health conditions and one for all other conditions. Submission of the incorrect form could result in delays in processing your patient's claim.

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

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

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

Group _____ Account _____ Certificate _____

Plan Member _____ _____ _____ Telephone (_____) _____
First Name Initial Last Name

Date of Birth _____ Height _____ Weight _____
MMM/DD/YYYY

Plan Sponsor/Employer Name _____ Telephone (_____) _____

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

Co-operators Life Insurance Company uses reasonable safeguards to protect all information it collects, uses, retains and discloses in the course of conducting business. However, the Internet is not a secure medium and we do not use email encryption. As such, we cannot guarantee complete privacy and confidentiality of any email transmissions. This includes the email text and any attachments. By authorizing communication by email, you are acknowledging that you have read and understood this notice and disclaimer and are consenting to the transmission of your personal information using email knowing the email and any attachments may be subject to unauthorized access, use or disclosure by third parties. You agree that Co-operators Life Insurance Company is not responsible or liable for any damages or losses you or any other person may suffer as a result of any breach of privacy, confidentiality or security by transmission of your personal information using email communication. If you no longer wish to communicate with Co-operators Life Insurance Company by email, please send notification to disability_claims_admin@cooperators.ca

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. Medical and health information excludes genetic test results.

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 _____

Secondary _____

Symptoms (include severity, frequency and duration) _____

_____

Date symptoms first appeared or accident occurred _____
MMM/DD/YYYY

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 _____

Blood Pressure _____ Date _____
MMM/DD/YYYY

Is condition due to injury or sickness arising out of patient's employment? ☐ Yes ☐ No ☐ Unknown If yes, provide details _____

_____

If condition is due to pregnancy, please give expected date of confinement _____
MMM/DD/YYYY

Date of first visit for present condition _____
MMM/DD/YYYY

Plan Member _____ _____ _____
First Name Initial Last Name

2. MEDICAL INFORMATION (CONTINUED)

Since first visit, how often have you seen this patient? ☐ Weekly ☐ Bi-weekly ☐ Monthly

Date of most recent visit _____ (MMM/DD/YYYY) Date of next visit _____ (MMM/DD/YYYY)

Has patient ever had same or similar condition? ☐ Yes ☐ No ☐ Unknown If yes, what precipitated absence from work? _____

Is condition considered chronic? ☐ Yes ☐ No If yes, what precipitated absence from work? _____

Date patient ceased work because of current condition _____ (MMM/DD/YYYY)

TREATMENT

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

Physiotherapy: ☐ Yes ☐ No If yes, frequency: ☐ Daily ☐ 3 X week ☐ Weekly ☐ Other _____

List any dates of hospitalizations: From _____ (MMM/DD/YYYY) To _____ (MMM/DD/YYYY) Name of Institution _____

From _____ (MMM/DD/YYYY) To _____ (MMM/DD/YYYY) Name of Institution _____

Surgery: ☐ Yes ☐ No If yes, type of surgery _____ Date: ☐ Performed ☐ Planned _____ (MMM/DD/YYYY)

Treatment Providers	Provider Speciality	Dates of Examinations

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

Describe any other recommended treatment or future plans. (Specify with dates) _____

Projected duration of treatment program _____

Summarize patient's response to treatment _____

Is patient following recommended treatment program? ☐ Yes ☐ No

If no, please explain _____

RESTRICTIONS AND LIMITATIONS

Are you aware of the duties of your patient's occupation? ☐ Yes ☐ No

Please describe the patient's current restrictions and limitations

Physical _____

Psychiatric/Cognitive _____

Do these medical restrictions or limitations affect your patient's ability to perform any other activities, including activities of daily living? ☐ Yes ☐ No

If yes, please explain _____

Is the patient competent to manage his/her own affairs? ☐ Yes ☐ No

Has the patient's driver's license been restricted or revoked as a result of this condition? ☐ Yes ☐ No

Plan Member _____ _____ _____
First Name Initial Last Name

2. MEDICAL INFORMATION (CONTINUED)

Are there any social or other non-medical factors that may impact the expected recovery period and the patient's return to work goals?

_____

_____

PROGNOSIS

Prognosis for improvement and recovery (include timelines) _____

_____

What return to work goals have been discussed with your patient? _____

_____

If your patient is unable to return to their regular occupation, please specify when and under what circumstances they could return to work (eg. modified duties, gradual return to work) _____

_____

ADDITIONAL COMMENTS

_____

_____

_____

_____

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. Medical and health information excludes genetic test results.

Attending Physician (Please Print) _____

Certified Speciality _____ Family Physician ☐ Yes ☐ No

Address _____ _____ _____ _____
Street City Province Postal Code

Telephone (_____) _____ Fax Number (_____) _____

Physician's Stamp

Physician Signature _____ Date _____
MMM/DD/YYYY

Co-operators Life Insurance Company Privacy Statement

At The 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 The Co-operators at 1-888-887-7773, or by e-mail: privacy@cooperators.ca