

GROUP BENEFITS CRITICAL ILLNESS - PHYSICIAN STATEMENT CEREBRAL PALSY

MAILING ADDRESS	INSTRUCTIONS
<p>Mail: Co-operators Life Insurance Company Life Claims Department 1900 Albert Street Regina SK S4P 4K8</p> <p>Phone: 1-866-442-3098</p> <p>Fax: 1-866-889-9925</p>	<p>Please print clearly and be sure all sections are complete to avoid delays in processing the claim.</p> <p>The confidential Medical Information section is to be completed by your physician.</p> <p>The Patient's parent/legal guardian is responsible for the cost of completing this form.</p> <p>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.</p> <p>The completed form must be faxed directly from the Physician's office or the original can be mailed to the address provided.</p>

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 MRI, CRANIAL ULTRASOUND, CT SCAN, EEG, LAB TESTS AND ALL TESTS FOR HEARING, VISION, MOTOR DEVELOPMENT, RESPIRATIONS AND COMMUNICATION DELAYS), DIAGNOSTICS, CONSULTATION REPORTS AND HOSPITALIZATION SUMMARIES.

2. Indicate the diagnosis for this patient:

3. Was this diagnosis made by a Pediatric Neurologist in Canada? Yes No

Please provide name of physician: _____

4. Date of Diagnosis _____
MMM/DD/YYYY

5. Date the diagnosis or possible diagnosis of Cerebral Palsy 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:

<input type="checkbox"/> Vision Impairment	_____	<small>MMM/DD/YYYY</small>
<input type="checkbox"/> Hearing Impairment	_____	<small>MMM/DD/YYYY</small>
<input type="checkbox"/> Speech Delays or Impairments	_____	<small>MMM/DD/YYYY</small>
<input type="checkbox"/> Intellectual Disabilities	_____	<small>MMM/DD/YYYY</small>
<input type="checkbox"/> Motor Delay	_____	<small>MMM/DD/YYYY</small>

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

2. MEDICAL INFORMATION (CONTINUED)

9. What tests were conducted to make this diagnosis?

10. Please provide details on how Cerebral Palsy has affected either one limb, one side of the body, the whole body or other:

11. Please describe the patient's current clinical presentation (e.g. weakness, spasticity, mental and motor impairment) and the 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 dates(s) and location(s):

13. 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:

14. Were there factors during pregnancy or birth that were associated with the eventual onset of Cerebral Palsy? Yes No

If yes, please provide details:

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

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