

GROUP BENEFITS CRITICAL ILLNESS - PHYSICIAN STATEMENT CYSTIC FIBROSIS

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 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

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 his/her 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:
