

GROUP BENEFITS CRITICAL ILLNESS - PHYSICIAN STATEMENT DOWN SYNDROME

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 (MEDICAL OR NEUROLOGICAL), INTERVIEWS, OBSERVATION AND EVALUATIONS, DIAGNOSTICS, CONSULTATION REPORTS AND HOSPITALIZATION SUMMARIES.

2. Indicate the diagnosis for this patient:

3. Date of Diagnosis _____
MMM/DD/YYYY

4. Date the diagnosis or possible diagnosis of Down Syndrome was first discussed with the parent/guardian of this patient _____
MMM/DD/YYYY

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

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

6. Date you were first consulted regarding this condition _____
MMM/DD/YYYY

7. What tests were conducted to make this diagnosis?

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

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