the co-operators®
A Better Place For You®

GROUP BENEFITS
LONG TERM DISABILITY
ATTENDING PHYSICIAN STATEMENT

FOR OFFICE USE ONLY

MAILING ADDRESS

Mail: Co-operators Life Insurance Company
Disability Claims Department
1920 College Avenue
Regina SK S4P 1C4
Fax: 1-866-889-9926

INSTRUCTIONS

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)

Plan Member _____ _____ _____
First Name Initial Last Name

Group _____ Account _____ Certificate _____

Plan Sponsor/Employer Name _____ Telephone Number (_____) _____

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

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.

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

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

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

Plan Member _____ _____ _____
First Name | Initial | Last Name

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2. MEDICAL INFORMATION (CONTINUED)

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

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

Plan Member _____ _____ _____
First Name | Initial | Last Name

2. MEDICAL INFORMATION (CONTINUED)

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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.

Attending Physician (Please Print) _____

Certified Speciality _____ Family Physician ☐ Yes ☐ No

Address _____ _____ _____ _____
Street | City | Province | Postal Code

Phone Number (_____)_____ Fax Number (_____) _____

Physician's Stamp

Physician Signature _____ Date _____
MMM/DD/YYYY

Co-operators Life Insurance Company Privacy Statement

Co-operators Life Insurance Company is committed to protecting the privacy, confidentiality, accuracy and security of the personal information that it collects, uses, retains and discloses in the course of conducting business.