the co-operators
A Better Place For You®

GROUP BENEFITS
DISMEMBERMENT PHYSICIAN STATEMENT

FOR OFFICE USE ONLY

MAILING ADDRESS

Mail: Co-operators Life Insurance Company
Group Life Claims
1920 College Avenue
Regina SK S4P 1C4

Fax: 1-866-889-9925

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 (______) ______________

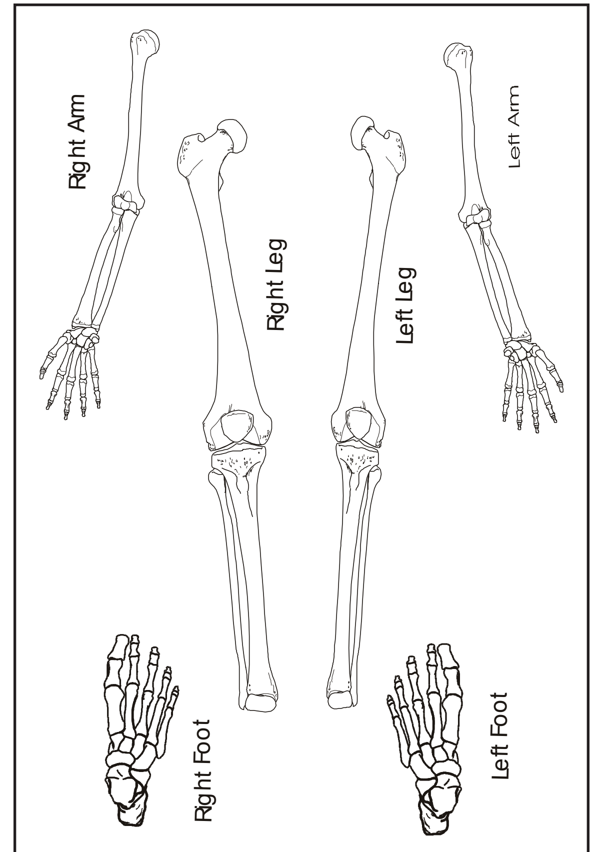
Date of Birth ____________ MMM/DD/YYYY

I hereby authorize my physician to release any medical information supporting my claim for 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.



1. Diagnosis ____________________ Date of Diagnosis ____________ MMM/DD/YYYY

2. If an accident ____________ MMM/DD/YYYY

   Nature of injury (location and extent) ______________________________

   ____

   Date of first treatment for this injury ____________ MMM/DD/YYYY

3. Dismemberment ☐ Hand ☐ Foot ☐ Arm ☐ Leg ☐ Finger

   If applicable, please use diagram indicating loss and level of amputation.

   Date of amputation ____________ MMM/DD/YYYY

   Was amputation necessary as a result of the accident/disease indicated above? ☐ Yes ☐ No

4. Loss of use ☐ Hand ☐ Arm ☐ Foot ☐ Leg ☐ Paraplegia ☐ Hemiplegia ☐ Quadriplegia

   Did the accident/disease result in total and irrecoverable loss of use/paralysis? ☐ Yes ☐ No

   If yes, provide details ______________________________

   ____

   ____

   Has the loss of use/paralysis been continuous for 12 months? ☐ Yes ☐ No

5. Loss of ☐ Vision ☐ Speech ☐ Hearing

   Percentage of loss ______%

   Will vision, speech or hearing be recovered or partially recovered by the use of a device or rehabilitative program? ☐ Yes ☐ No

   If yes, provide details ______________________________

   ____

   ____

   Date on which loss of sight occurred ____________ MMM/DD/YYYY If accident/disease required removal of eye, date ____________ MMM/DD/YYYY

   Vision in each eye prior to accident/disease: Right ________ Left ________ Present vision, if any, in each eye: Right ________ Left ________

6. Was the accident/disease described above solely responsible for the loss? ☐ Yes ☐ No

   If no, provide details of any contributing cause(s) ______________________________

   ____

   ____

Plan Member ____________________ ______ ____________________
First Name Initial Last Name

3. PHYSICIAN ACKNOWLEDGEMENT AND AUTHORIZATION

I hereby declare that the answers to the above questions are accurate and complete.

Attending Physician (Please Print) ____________________

Address ____________________ ____________________ ____________________ ____________________
Street City Province Postal Code

Certified Speciality ____________________ Family Physician ☐ Yes ☐ No

Phone Number (______)__________________ Fax Number (_______)____________________

Physician Signature ____________________

Date ____________________
MMM/DD/YYYY

Physician's Stamp

FOR OFFICE USE ONLY

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.