the co-operators®
A Better Place For You®

GROUP BENEFITS
EARLY INTERVENTION
ATTENDING PHYSICIAN STATEMENT

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

- **If your patient has returned to work or is expected to return to work within 6 weeks of the last date worked, complete section 2 and sign the end of the form**
- **For absences expected to be greater than 6 weeks, please complete all sections**
- **Please attach copies of chart notes, test results, and consultation reports**

Primary Diagnosis _____

Secondary Diagnosis _____

DSM-IV, if applicable Axis I _____ Axis II _____ Axis III _____ Axis IV _____

Current GAF _____ Previous GAF _____ Date _____
MMM/DD/YYYY

Symptoms (include severity, frequency and duration) _____

_____

_____

Date symptoms first appeared or accident occurred _____
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

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

Name of Medication	Dosage	Dated Initiated	Reason for change in medication if applicable
		_____ MMM/DD/YYYY	
		_____ MMM/DD/YYYY	
		_____ MMM/DD/YYYY	

Plan Member _____ (First Name) _____ (Initial) _____ (Last Name)

Physiotherapy ☐ Yes ☐ No If yes, frequency ☐ Daily ☐ 3 times/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)

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) _____

3. ABSENCES GREATER THAN 6 WEEKS

Investigations (e.g. EKG's, x-rays, lab tests, etc.)	Date Carried Out	Summary of Results (attach copies of all available reports)
	MMM/DD/YYYY	
	MMM/DD/YYYY	
	MMM/DD/YYYY	
	MMM/DD/YYYY	

Are any further investigations planned? ☐ Yes ☐ No

If yes, state type and when _____

Blood Pressure _____ Date _____ (MMM/DD/YYYY)

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

Date of last visit _____ (MMM/DD/YYYY) Date of next visit _____ (MMM/DD/YYYY)

Treatment Providers	Speciality	Dates of Examinations
		MMM/DD/YYYY
		MMM/DD/YYYY
		MMM/DD/YYYY
		MMM/DD/YYYY

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 _____

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

Are you aware of the duties of your patient's occupation? ☐ Yes ☐ No

Please describe the patient's current restriction 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 drivers 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?

_____

_____

ADDITIONAL COMMENTS

_____

_____

_____

_____

4. 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

If you would like The Co-operators to communicate with you by email about this disability claim, please provide your email _____

We use reasonable safeguards to protect all information collected, used, retained and disclosed in the course of conducting business; however, email may be vulnerable to interception by unauthorized parties. We discourage you from emailing personal or sensitive information. If you provided your email to us, or if you contacted us by email, we accept this as your consent to communicate with you by email. If you do not wish for us to communicate with you by email, please notify us at your earliest convenience.

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.