

To: **Group Life Claims Department**  
**1920 College Avenue, Regina, SK S4P 1C4**

Name of insured person \_\_\_\_\_ Date of Birth \_\_\_\_\_

Policy No. **G.** \_\_\_\_\_ PID# \_\_\_\_\_

**STATEMENT OF GROUP EMPLOYER/GROUP POLICYHOLDER**

Total benefit amount as per shown in contract \$ \_\_\_\_\_ Amount being claimed \$ \_\_\_\_\_

Date of employment \_\_\_\_\_ Effective date of insurance \_\_\_\_\_

If insurance has been cancelled, give date and reason \_\_\_\_\_

Date last worked \_\_\_\_\_ Date of return to work \_\_\_\_\_

Is claim due to an occupational accident?  YES  NO Is claim being made to Workmen's Compensation Board?  YES  NO

Give any additional information which might assist the company in considering this claim \_\_\_\_\_

Name of group policyholder \_\_\_\_\_

Signature \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_

Name \_\_\_\_\_ Telephone No. ( \_\_\_\_\_ ) \_\_\_\_\_  
(please print)

**STATEMENT OF CLAIMANT**

Date and Time of accident \_\_\_\_\_ Date of hospital confinement, if any: From \_\_\_\_\_ To \_\_\_\_\_

Physician's name and address (PLEASE PRINT) \_\_\_\_\_

Describe the circumstances surrounding your accident. Give complete details \_\_\_\_\_

Police investigation? If so name detachment \_\_\_\_\_

If this was a MVA: Was alcohol involved?  YES  NO

Was it reported to the police?  YES  NO (Attach copy of police report.) Tel. # \_\_\_\_\_

Name of detachment \_\_\_\_\_ Name of investigating officer \_\_\_\_\_

**AUTHORIZATION:** I hereby authorize any physician or practitioner who has observed or may hereafter observe me for diagnosis or treatment and any hospital or clinic where I have been or may hereafter become a patient, and any insurance company, law enforcement agency, governmental department or any organization, that has any records or knowledge of me or my health, to give full particulars thereof including any prior medical history to Co-operators Life Insurance Company.

**A photostat of this authorization shall be as valid as the original.**

Signed at \_\_\_\_\_ Date \_\_\_\_\_

Signature of Claimant \_\_\_\_\_

Address of Claimant \_\_\_\_\_ Postal Code \_\_\_\_\_

Telephone ( \_\_\_\_\_ ) \_\_\_\_\_

**NOTE TO CLAIMANT - PLEASE HAVE REVERSE SIDE COMPLETED BY THE ATTENDING PHYSICIAN**

# STATEMENT OF ATTENDING PHYSICIAN

1. **A.** Patient's name \_\_\_\_\_ **B.** Date of Accident \_\_\_\_\_  
**C.** Nature of injury (location and extent) \_\_\_\_\_

D. Date of first treatment for this injury \_\_\_\_\_

2. **Loss of:**  Hand  
 Foot  Arm  
 Leg  Finger

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

**B.** Date of amputation \_\_\_\_\_

3. Did the accident result in **total and irrecoverable loss of**

- Vision  Speech  Hearing

Will vision, speech or hearing be recovered or partially recovered by the use of some device or rehabilitative program?  YES  NO **If "yes", provide details.**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**C.** Date on which loss of sight occurred \_\_\_\_\_

**D.** If injury necessitated removal of eye, date of removal \_\_\_\_\_

**E.** Vision in each eye prior to accident:  
 right \_\_\_\_\_ left \_\_\_\_\_

**F.** Present vision, if any, in each eye:  
 right \_\_\_\_\_ left \_\_\_\_\_

4. **Loss of use:**  Hand  Arm  Leg  Paraplegia  Hemiplegia  Quadriplegia

**A.** Did the accident result in **total and irrecoverable loss of use/paralysis?** \_\_\_\_\_

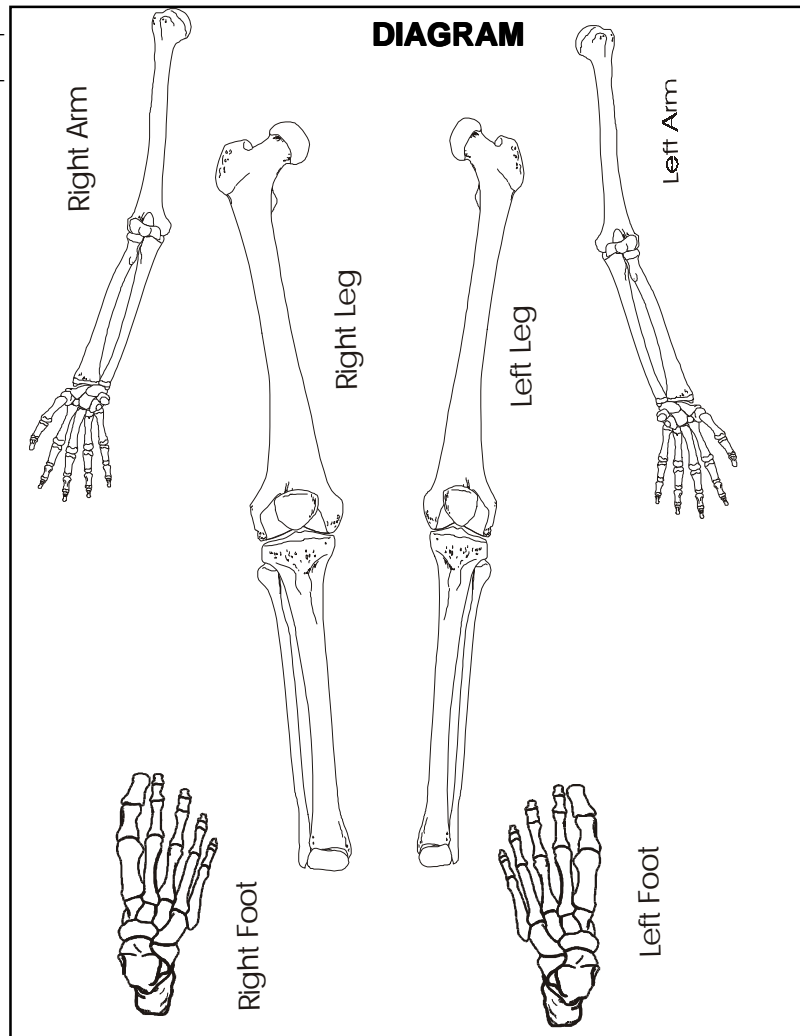
If yes, please give explicit details \_\_\_\_\_

**B.** Has the loss of use/paralysis been continuous for 12 months?  YES  NO

5. Was the injury described above solely responsible for the loss?  YES  NO

If not, give particulars of any contributing cause or causes. \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_



★ ★ ★ Please attach copies of all consult/surgical reports to avoid delay in adjudication. ★ ★ ★

Date \_\_\_\_\_ Signature \_\_\_\_\_

Name \_\_\_\_\_ Telephone No. \_\_\_\_\_  
 (Please print or use stamp) **Specialty** \_\_\_\_\_

Address \_\_\_\_\_ Postal Code \_\_\_\_\_

**ANY CHARGE FOR COMPLETING THIS FORM IS THE RESPONSIBILITY OF THE CLAIMANT (PATIENT).**