



CO-OPERATORS LIFE INSURANCE COMPANY

1920 College Avenue, Regina Saskatchewan S4P 1C4

APPLICATION FOR GROUP WEEKLY INDEMNITY INSURANCE

Physician Statement (Please Print)

AUTHORIZATION

I authorize the release to the plan administrator and/or plan adjudicator, insurer and my policyholder of any medical information requested for this claim.

Name of Patient (please print)

Signature of Patient (Claimant)

Patient's Date of Birth

Today's Date

Note:The patient is responsible for obtaining this form and any charges for its completion , except in those provinces governed by statutory regulations that prohibit.

ATTENDING PHYSICIAN'S STATEMENT DIAGNOSIS

| | |
|---------|-----------|
| Primary | Secondary |
|---------|-----------|

Other contributing factors/complications

If condition is due to pregnancy, please give expected date of confinement.

Day Month Year

PRESENT CONDITION

| | | |
|--|---|---|
| Symptoms first appeared or accident happened | Date patient ceased work because of present condition | Date of first visit for present condition |
| Day Month Year | Day Month Year | Day Month Year |

Has patient ever had same or similar condition? No Yes Unknown If "Yes", state original date of illness/injury and provide details.

.....
.....

SUBJECTIVE AND OBJECTIVE FINDINGS/INVESTIGATIONS

| | | | |
|--------|--------|----------------|-------|
| Height | Weight | Blood Pressure | Pulse |
|--------|--------|----------------|-------|

Cardiac (if applicable)
 Class 1 (no limitation) Class 2 (slight limitation) Class 3 (marked limitation) Class 4 (complete limitation)

Physical Limitations
(e.g. range of motion; restrictions on lifting, bending, walking; etc.)

Subjective symptoms (Attach a copy of chart notes from the date of first visit for present condition)

DSM - IV Diagnosis - Axis I: _____ Axis III: _____ Axis V: _____
Axis II: _____ Axis IV: _____ - Current GAF & Date: _____
- Highest GAF in past year: _____

| Investigations (e.g. EKG's, x-ray, lab tests, etc.) | Date Carried out | Summary of Results (Attach copies of all available reports.) |
|---|------------------|--|
| | | |
| | | |
| | | |

Are any further investigations planned? No Yes If "Yes", state type and when.

Physician Statement (continued)

Has your patient been referred to any other physician/specialist? No Yes If "Yes", complete the following chart.

| Physician's / Specialist Name | Specialty | Dates of Examinations |
|-------------------------------|-----------|-----------------------|
| | | |
| | | |
| | | |

Summarize physician's findings.

TREATMENT

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

Date last treated for condition _____ Date of next treatment for condition _____

List current medications, dosages, and date commenced. Provide reasons for changes to same.

| | | | |
|---|--|--|--|
| Dates of hospital admission(s) From Day Month Year To Day Month Year | | From Day Month Year To Day Month Year | |
| Physiotherapy? <input type="checkbox"/> No <input type="checkbox"/> Yes If "Yes", frequency <input type="checkbox"/> Daily <input type="checkbox"/> 3x per Week <input type="checkbox"/> Weekly <input type="checkbox"/> Other. | | Type of physiotherapy <input type="checkbox"/> outpatient/physiotherapy dept. <input type="checkbox"/> independent home exercises | |
| Surgery? <input type="checkbox"/> No <input type="checkbox"/> Yes If "Yes", type of surgery | | Date of surgery <input type="checkbox"/> performed <input type="checkbox"/> planned Day Month Year | |

Any other treatment or future plans for treatment? (Specify with dates.)

LIMITATIONS

Are you aware of what your patient's job duties are?

What major tasks of your patients occupation is he/she able to perform?

Unable to perform? (Please list specifics that impair functional activity).....

What daily living activities are impaired due to this illness and how?.....

What is being done to return your patient to work

Is patient Ambulatory House confined Bed confined

PROGNOSIS

Progress: Has patient Recovered Not Improved Improved Retrogressed

1. Have you discussed a return to work date with your patient?

Yes If "Yes", have you discussed a return to work at: Own Occupation Full-Time Date _____ or Other Occupation Full-Time Date _____
 Part-Time Date _____ Part-Time Date _____

No If "No", please explain:

Estimated number of weeks before possible return to work

Would vocational counselling and/or retraining be beneficial? No Yes If "Yes" please advise date and provide comments

| | | | |
|---|-----------------|---------------------------------|-------------|
| Physician's name (please print) | | Fax No. () | |
| Last Name | Initials | Telephone No. () | |
| Address | | Province | |
| No. & Street | Suite / Apt.No. | City / Town | Postal Code |
| Signature of physician | | Date | |
| Family Physician <input type="checkbox"/> No <input type="checkbox"/> Yes | | Specialist (Indicate Specialty) | |



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APPLICATION FOR GROUP WEEKLY INDEMNITY INSURANCE

Employer Statement (Please Print)

| CLAIMANT INFORMATION | |
|--|--|
| Claimant's name <input type="checkbox"/> Miss <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. Last name: _____ First Name: _____ | |
| Policy / plan no. | Division _____ S.I.N.No. (for taxable plans only) |
| Date of Birth If age 60 over, copy of birth certificate must be enclosed with claimant's statement | Sex <input type="checkbox"/> Male <input type="checkbox"/> Female Telephone No. () |
| Address No. & Street _____ Suite / Apt.No. _____ City / Town _____ Province _____ Postal Code _____ | |
| Occupation State occupation held just before stopping work | Is condition due to injury or illness arising out of employment? <input type="checkbox"/> No <input type="checkbox"/> Yes If "Yes", has the employee applied for Worker's Compensation Benefits? <input type="checkbox"/> No <input type="checkbox"/> Yes If "No" please provide details Note: If illness/injury is claimed to be work related, the employee must make application to the Worker's Compensation Board for benefits in addition to this plan. |

| COVERAGE INFORMATION | | |
|---|--|--|
| Date of employment Day _____ Month _____ Year _____ | Effective date of coverage Day _____ Month _____ Year _____ | If employment now terminated, please indicate effective date and/or reason Day _____ Month _____ Year _____ |
| Date Last Worked Day _____ Month _____ Year _____ | Have you discussed a return to work with your employee? <input type="checkbox"/> Yes If "Yes" have you discussed a return to work at: Own Occupation <input type="checkbox"/> Full-Time Date ____ <input type="checkbox"/> Part-Time Date ____ or New Job/Duties <input type="checkbox"/> Full-Time Date ____ <input type="checkbox"/> Part-Time Date ____ <input type="checkbox"/> No If "No" please explain | Date returned to work Day _____ Month _____ Year _____ Average hours worked per week prior to ceasing work _____ (excluding overtime) |
| Class/group/union affiliation to which claimant belongs (if applicable) | <input type="checkbox"/> Salaried <input type="checkbox"/> Full-Time <input type="checkbox"/> Hourly <input type="checkbox"/> Part-Time <input type="checkbox"/> Contract (please enclose a copy of the contract agreement) | What days of the week does your employee work? ie. Mon.to Fri. |

| EARNINGS / BENEFIT INFORMATION | |
|---|---|
| State rate of earned gross income immediately before stopping work \$ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Annually <input type="checkbox"/> Hourly <input type="checkbox"/> Bi-weekly | Date rate of earned gross income became effective Day _____ Month _____ Year _____ |
| State claimant's net earned income (after tax deductions, CPP and U.I.C.) immediately before stopping work \$ (Please attach copy of last pay stub) | Is any portion of the premium paid for by the policyholder/ employer? <input type="checkbox"/> No (non taxable) <input type="checkbox"/> Yes (taxable) |
| Current tax exception per Federal TD1 \$ _____ (attach TD1) | Other income (sick pay) From _____ To _____ Day _____ Month _____ Year _____ Day _____ Month _____ Year _____ |

| | |
|---|--|
| Name of employer or organization | Telephone No. _____ Fax.No. _____ () () |
| Address No. & Street _____ Suite / Apt.No. _____ City / Town _____ Province _____ Postal Code _____ | |
| Form completed by (other than person claiming) _____ Name (Please Print) _____ Title _____ _____ Signature _____ Date _____ | |

Employee Statement (Please Print)

Briefly describe your duties

Please provide education level - 1 2 3 4 5 6 7 8 9 10 11 12 Secondary -

Describe your present medical condition, it's cause and history

| | |
|--|--|
| Date of first treatment for this illness/injury | Medical condition has prevented you from working since |
| Day Month Year | Day Month Year |

Have you ever had a similar injury or illness in the past? No Yes If "Yes", describe your condition and the original date of illness or injury.

| | |
|---|--|
| Have you or did you attempt to return to work? <input type="checkbox"/> No <input type="checkbox"/> Yes | If your condition is the result of an injury/accident or motor vehicle accident, please describe the events surrounding the accident: a) Was another party at fault? <input type="checkbox"/> Yes <input type="checkbox"/> No b) Was alcohol involved in the events surrounding the accident? <input type="checkbox"/> Yes <input type="checkbox"/> No c) Was it reported to police? <input type="checkbox"/> Yes <input type="checkbox"/> No (if Yes, attach a copy of police report) d) Were any charges laid? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, against whom? e) Are you pursuing a claim for wage loss against a third party? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, please give reasons: |
|---|--|

ACCIDENT INFORMATION - COMPLETE ONLY IF CLAIM IS THE RESULT OF AN ACCIDENT.

| | | |
|--|--|---|
| Date of Accident | Time of accident | Was work being done for an employer at time of accident? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Day Month Year | <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. | |

Particulars of accident:

Are you claiming or receiving any other disability, wage loss, and/or retirement benefits? No Yes If "Yes", complete this section .

| Type | Amount | Frequency | Effective | Claim No. |
|--|--------|-----------|-----------|-----------|
| <input type="checkbox"/> WCB | | | | |
| <input type="checkbox"/> CPP/QPP | | | | |
| <input type="checkbox"/> Car Insurance | | | | |
| <input type="checkbox"/> UIC | | | | |
| <input type="checkbox"/> Other (e.g.legal action) | | | | |

NOTE: ATTACH COPIES OF ALL CORRESPONDENCE YOU HAVE RECEIVED, RELATED TO THE ABOVE MATTER

CLAIMANT AUTHORIZATION AND ASSIGNMENT

I HEREBY AGREE TO REFUND ANY MONIES WHICH MAY BE DUE TO THE INSURANCE COMPANY, POLICYHOLDER OR PLAN ADMINISTRATOR AS A RESULT OF PAYMENT OF DISABILITY BENEFITS FROM ANY SOURCE LISTED IN OTHER INCOME, IN ACCORDANCE WITH THE PROVISIONS OF THE POLICY / PLAN DOCUMENT AND FURTHER ASSIGNS SUCH MONIES TO THE INSURANCE COMPANY.
 I HAVE READ THE FOREGOING, AND THE ABOVE ANSWERS ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF. I AUTHORIZE ANY HOSPITAL, PHYSICIAN, MEDICAL HEALTH CARE PROFESSIONAL, OR OTHER MEDICAL OR MEDICALLY RELATED INSTITUTION, INSURANCE COMPANY, EMPLOYER, GOVERNMENT AGENCY, OR OTHER ORGANIZATION, INSTITUTION OR PERSON, TO RELEASE TO CO-OPERATORS LIFE INSURANCE COMPANY, THE PLAN ADJUDICATOR, OR THE PLAN ADMINISTRATOR, ANY AND ALL INFORMATION WITH RESPECT TO ANY ILLNESS, INJURY, MEDICAL HISTORY, CONSULTATION, PRESCRIPTIONS, TREATMENT AND TO PROVIDE COPIES OF ANY OTHER RECORDS RELATING TO THE INSURED'S HEALTH. A FACSIMILE TRANSMISSION OR PHOTO COPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS VALID AS THE ORIGINAL.

_____ *Signature of employee* _____ *Date* _____

PLEASE USE A SEPARATE SHEET FOR ADDITIONAL COMMENTS