



## ATTENDING PHYSICIAN'S Statement For Disability Insurance Claim

Any person who knowingly and with intent to defraud an insurance company or other person files a statement containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

**Name of Patient:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Present Address:** \_\_\_\_\_ **Policy Number:** \_\_\_\_\_

We must have comprehensive medical information in order to evaluate the insured's claim for Disability Benefits. Any charge required for completion of this form is the responsibility of the patient.

<b>1. History</b>	<b>a. When did symptoms first appear or accident happen?</b>	Month/Day/Year
	<b>b. Date disability commenced:</b>	Month/Day/Year
	<b>c. Has patient ever had same or similar condition?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
	<b>If "Yes", state when and describe:</b>	
<b>2. Diagnosis</b> (including any complications)	<b>a. Date of last examination:</b>	Month/Day/Year
	<b>b. Diagnosis (including any complications):</b>	
	<b>c. Subjective symptoms:</b>	
	<b>d. Objective findings (including current X-rays, EKG's, Laboratory Data and any clinical findings):</b>	
<b>3. Dates of treatment</b>	<b>a. Date of first visit:</b>	Month/Day/Year
	<b>b. Date of last visit:</b>	Month/Day/Year
	<b>c. Frequency:</b> <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other (specify) _____	
<b>4. Nature of treatment</b> (including surgery and medications prescribed, if any)	<b>Will treatment substantially improve function and employability?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
	<b>If "Yes", specify:</b>	
<b>5. Progress</b>	<b>a. Has patient</b> <input type="checkbox"/> recovered? <input type="checkbox"/> improved? <input type="checkbox"/> unchanged? <input type="checkbox"/> retrogressed?	
	<b>b. Is patient</b> <input type="checkbox"/> bed confined? <input type="checkbox"/> hospital confined? <input type="checkbox"/> ambulatory? <input type="checkbox"/> house confined?	
	<b>c. Has patient been hospital confined?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
	<b>If "Yes", give name and address of hospital:</b> Confined from _____ through _____	
<b>6. Cardiac</b> (if applicable)	<b>a. Functional capacity</b> <input type="checkbox"/> Class 1 (No limitation) <input type="checkbox"/> Class 2 (Slight limitation) (American Heart Association) <input type="checkbox"/> Class 3 (Marked limitation) <input type="checkbox"/> Class 4 (Complete limitation)	
	<b>b. Blood pressure (last visit):</b> Systolic _____ Diastolic _____	

(continued on the next page)

<b>7. Limitation</b> (If there is a limitation, check and describe)	Standing	Climbing	Bending	Use of Hands	Sitting
	Walking	Stooping	Lifting	Psychological	Other (specify)
<b>8. Physical impairment</b>	<input type="checkbox"/> Class 1- No limitation of functional capacity; capable of heavy work* No restrictions (0-10%) <input type="checkbox"/> Class 2- Medium manual activity* (15-30%) <input type="checkbox"/> Class 3- Slight limitation of functional capacity; capable of light work* (35-55%) <input type="checkbox"/> Class 4- Moderate limitation of functional capacity; capable of clerical/administrative (sedentary*) activity (60-70%) <input type="checkbox"/> Class 5- Severe limitation of functional capacity; incapable of minimal (sedentary*) activity (75-100%)				
	Remarks:				
<b>9. Mental/Nervous Impairment</b> (if applicable)	<b>Please define "stress" as it applies to this claimant:</b> <input type="checkbox"/> Class 1- Patient is able to function under stress and engage in interpersonal relations (no limitations) <input type="checkbox"/> Class 2- Patient is able to function in most stress situations and engage in most interpersonal relations (slight limitations) <input type="checkbox"/> Class 3- Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations (moderate limitations) <input type="checkbox"/> Class 4- Patient is unable to engage in stress situations or engage in interpersonal relations (marked limitations) <input type="checkbox"/> Class 5- Patient has significant loss of psychological, physiological, personal and social adjustment (severe limitations)				
	Remarks:				
	Do you believe the patient is competent to endorse checks and direct the use of proceeds thereof? <input type="checkbox"/> Yes <input type="checkbox"/> No				
<b>10. Extent of Disability</b>			<b>From any Occupation</b>	<b>From Patient's Regular Occupation</b>	
	<b>a. Is the patient now totally disabled?</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<b>b. If no, when was patient able to go to work?</b>		Month/Day/Year	Month/Day/Year	
	<b>c. If yes, when do you think patient will be able to resume any work?</b>		Approximate date	Month/Day/Year	Month/Day/Year
			Indefinite Never	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
<b>11. Rehabilitation</b>	<b>a. Is patient a suitable candidate for further rehabilitation services?</b>		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	<b>b. Can present job be modified to allow for handling with impairment?</b>		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	<b>c. When could trial employment commence?</b>		<b>Patient's Job</b>		<b>Any Other Work</b>
			Month/Day/Year	Month/Day/Year	
			<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	
<b>d. Would vocational counseling and/or retraining be recommended?</b>		<input type="checkbox"/> Yes	<input type="checkbox"/> No		
<b>12. Remarks</b>					

\_\_\_\_\_  
Attending Physician's Name (Printed)

\_\_\_\_\_  
Signature (Attending Physician)

\_\_\_\_\_  
Specialty

\_\_\_\_\_  
Date

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
Telephone

\_\_\_\_\_  
City, State, Zip

# FRAUD WARNING NOTICE

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The laws of some states require us to furnish you with the following notice:

**Alabama** – Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

**Arkansas, Louisiana, Massachusetts, Rhode Island** – Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Colorado** – It is unlawful to knowingly provide false, incomplete, or misleading material facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading material facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the department of regulatory agencies.

**District of Columbia** – WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

**Florida** – Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**Hawaii** – For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

**Kentucky** – Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

**Maine, Tennessee, Virginia, Washington** – It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

**Maryland** – Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Minnesota** – A person who submits an application or files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

**New Jersey** – Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

**New Mexico** – Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

**Ohio** – Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**Oklahoma** – Any person who knowingly, with intent to injure, defraud or deceive any insurer, makes a claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

**Pennsylvania** – Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**Puerto Rico** – Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars (\$5,000) and not more than ten thousand dollars (\$10,000) or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

**All Other States** – Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.