A Guide for Successfully Completing the Group Long-Term Disability Claim Form

Mutual of Omaha appreciates the opportunity to provide you with valuable income protection. We rely on the information you provide on this form to effectively determine if you qualify for group long-term disability benefits.

This guide provides information and instruction to help you successfully complete and submit the claim form. Please consult your employer/benefits administrator if you need assistance in providing information for the form.

Important Tips for Paper Copy Submission

- Prior to submission, make sure all required information is provided and all questions have been answered completely and accurately. If information is missing or is illegible (unreadable), the processing of your form will be delayed.
- Refer to the guidelines for each section below, which provide valuable information to help you successfully complete the form.
- Make a copy of the completed form for your records before submitting it to Mutual of Omaha / United of Omaha.

Guidelines for Section 1: Employee's Statement

This section is to be completed by the Employee. Please answer all questions in order to avoid possible delays. All dates should indicate the month, date and year.

A. Information About You

- The Group Policy Number will have eight characters, beginning with "G000" followed by four additional letters or numbers specific to your employer.
- Provide weight in pounds, and height in feet and inches.
- Your Occupation / Job Title is the title of your position held with the employer.
- Indicate any other Mutual / United of Omaha plans in which you are currently insured.

C. Information About Your Disabling Condition

- The Date First Treated is the date you first sought out medical care because of the disabling condition.

D. Information About Work

- The Last Day Worked is the day before you were first absent from work because of the disabling condition.

E. Information About Care and Treatment

- Provide the name, specialty, phone and address for each doctor or hospital that treated you for the disabling condition.

F. Information About Other Income Benefits

- Other income means money you are currently receiving or have applied to receive from any source in addition to your claim for disability benefits with Mutual of Omaha / United of Omaha.
- Check all sources of other income that apply.

G. Information For Tax Withholding

- If your claim is paid, indicate whether or not you would like Mutual of Omaha to withhold income tax from your benefit payment, and if so, how much. Minimum is **$88** per month.

H. Signature

- Your signature is required.

Education, Training and Work Experience

- This form is to be completed by the employee. Please make sure all questions have been answered completely and accurately. If information is missing or is illegible (unreadable), the processing of your form will be delayed.
- Vocational rehabilitation services include, but are not limited to (a) job modification; (b) job placement; (c) retraining; and (d) other activities reasonably necessary to help you return to work.

Authorization to Disclose Personal Information

This authorization is to be completed by the employee.

- Please read this section in its entirety. By signing the authorization, you are applying for long-term disability benefits with Mutual of Omaha / United of Omaha, and are agreeing to allow disclosure of personal information to the necessary parties for purposes of claim processing.
- If the name associated with any of your medical records differs from the name provided on the form, provide any alternate names. This might occur in the event of a name change due to marriage or adoption, for example.
- IMPORTANT: To be complete, the form must be signed by you.

Guidelines for Section 2: Employer's Statement

This section is to be completed by the employer. Please answer all questions in order to avoid possible delays. All dates should indicate the month, date and year.

A. Information About the Employer

- The Group Policy Number will have eight characters, beginning with "G000" followed by four additional letters or numbers.

B. Information About the Employee

- The Date Employee Became Insured Under This Plan indicates the date in which the employee's coverage became effective.
- The Date Employee Became Insured Under Prior Plan indicates the date in which the employee's coverage was in effect under a plan prior to the Mutual of Omaha plan.
- The No. of Hours Employee Regularly Works is the number of hours the employee is typically scheduled per day / per week for the employer.

C. Information For Tax Withholding

- If this section is not completed, Mutual of Omaha will assume that premium paid by the employee is with pre-tax dollars.
- If this is not true, indicate otherwise and provide the percentage amount.

E. Information For Life Waiver

- Date Life Insurance Terminated means the first day the coverage is no longer in force.
- If applicable, the Paid To date for group life insurance is the date on which the next premium is due.

F. Information About Your Pension Plan

- This section is not applicable if the disabling condition is maternity.

H. Information About Employee's Salary

- Indicate the method in which the employee is paid.
- If hourly, also indicate the hourly rate in which the employee is paid.
- Please attach supporting payroll documentation.

GUIDELINES FOR SECTION 3: JOB ANALYSIS

This section is to be completed by the employer. Please answer all questions in order to avoid possible delays. All dates should indicate the month, date and year.

A. Information About the Employee's Job

- Occasionally means the employee does this activity up to 33% of the time.
- Frequently means the employee does the activity 34% to 66% of the time.
- Continuously means the employee does the activity 67% to 100% of the time.

B: Physical Aspects of the Job

- Check all the activities that apply to the employee's job.
- Indicate the frequency with which the employee performs the activity using the guidelines in section A. Information About the Employee's Job.

GUIDELINES FOR SECTION 4: SIGNATURE AND ATTACHMENTS

- Attach a copy of the employee's job description to the claim application.
- Attach any additional documentation that may be helpful when reviewing the application, including further explanation of any question(s) on the application.
- Your signature is required.

GUIDELINES FOR SECTION 5: PHYSICIAN'S STATEMENT

This section is to be completed by the attending physician. Please answer all questions in order to avoid possible delays. All dates should indicate the month, date and year.

REQUIRED FRAUD WARNINGS

Before completing the claim form, please read the Required Fraud Warnings listed provided on the following page.

REQUIRED FRAUD WARNINGS (STATE SPECIFIC WARNINGS APPLY TO THE RESIDENT OF SUCH STATE)

- **Fraud Warning:** 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.
- **Arkansas/Kentucky/Louisiana/Maine/New Mexico/Ohio/Tennessee:** Any person who, with intent to defraud or knowing that he/she 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.
- **California:** For your protection California law requires the following to appear on this form: Any person who knowlingely presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.
- **Colorado:** It is unlawful to knowingly provide false, incomplete, or misleading 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 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:** 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.
- **Kansas:** 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 as determined by a court of law.
- **Maryland:** Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
- **New Jersey:** Any person who includes any false or misleading information on an application for insurance is subject to criminal and civil penalties.
- **New York:** 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.
- **Oregon:** 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 may be crime and may subject such person to criminal and civil penalties.
- **Puerto Rico:** Any person who knowingly, and with intent to defraud or deceive any insurance company includes false information in an application for insurance or files, assists, or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefits, or files more than one claim for the same loss or damage, may be guilty of a felony. Upon conviction, that person will be fined between $5,000 and $10,000, imprisoned for three (3) years or both. Aggravating or attenuating circumstances may result in the prison term being increased to five (5) years or reduced to two (2) years.
- **Vermont:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claims containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may be committing a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.
- **Virginia:** Any person who, with the 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 may have violated state law.

Long-Term Disability Claim Form

Mutual of Omaha Insurance Company
United of Omaha Life Insurance Company
Group Disability Management Services
Mutual of Omaha Plaza, Omaha, NE 68175 – 0001
Phone (800) 877-5176 Fax (402) 997-1865

Section 1 – Employee's Statement (Answer all questions to avoid delay.)

A. Information About You

Last Name	First Name	Middle Initial	Group Policy Number

Address	City	State/Province	Zip

Telephone ( )	Email Address	Social Security Number

Date of Birth	Height	Weight	___ Male ___ Female	___ Right Handed ___ Left Handed	___ Single ___ Married	___ Widowed ___ Divorced

Name of Your Employer (include Division / Location, if applicable)	Your Occupation / Job Title

Under what other Mutual of Omaha / United of Omaha policies are you currently covered?

Important Notice: If you are age 60 or over, please contact your employer within 31 days of disability to preserve your group life insurance conversion privileges.

B. Information About Your Family (Required to determine your eligibility for Social Security benefits.)

Spouse's Name	Spouse's Social Security Number	Spouse's Date of Birth	Is your spouse employed? ___ Yes ___ No

First and Last Name of any children under the age of 25 — Date of Birth

_____ _____
_____ _____
_____ _____

C. Information About Your Disabling Condition

1. If your disability is due to an injury, answer the following questions and then proceed to #3 below.

When did the injury occur?

Where and how did the injury occur?

What is the date you were first treated by a physician?

2. If your disability is due to a pregnancy or an illness, answer the following questions. If <u>not</u> pregnancy-related, proceed to #3 below.

What were your first symptoms?

When did you notice these symptoms?

What is the date you were first treated by a physician?

3. If your disability is due to due to an injury or an illness, but not pregnancy, answer the following questions.

Why are you unable to work?

Before you stopped working, did your condition require you to change your job or the way you did your job? ___ Yes ___ No If **Yes**, please explain below.

Is your condition related to your occupation? ___ Yes ___ No If **Yes**, please explain below.

Have you filed, or do you intend to file a Workers' Compensation claim? ___ Yes ___ No

D. Information About Work

What is the date of your last day worked before the disability?	On your last day worked, did you work a full day? ___ Yes ___ No If **No**, please explain.
What is the date you were first unable to work?	Have you returned to work? ___ Yes, Part-Time ___ Yes, Full-Time ___ No What date did you return to work?

If you haven't yet returned to work, do you expect to? ___ Yes, Part-Time ___ Yes, Full-Time ___ No

What date do you expect to be able to return to work?

Are you currently self-employed or working for another employer? ___ Yes ___ No If **Yes**, provide details.

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E. Information About Care and Treatment (If additional space is needed, please provide details on a separate page.)

Doctor who **first** provided medical attention to you for your current disability.	Doctor's Specialty	Telephone ( ) Fax ( )
Doctor's Address		Date(s) you were seen by this doctor From _____ To _____

List all other physicians and/or hospitals you have seen for this condition below.

Doctor's Name	Doctor's Specialty	Telephone ( ) Fax ( )
Doctor's Address		Date(s) you were seen by this doctor From _____ To _____
Doctor's Name	Doctor's Specialty	Telephone ( ) Fax ( )
Doctor's Address		Date(s) you were seen by this doctor From _____ To _____
Name of Hospital	Department of Treatment	Telephone ( ) Fax ( )
Hospital's Address		Date(s) you were treated at the hospital From _____ To _____

Have you ever had the same or a similar condition in the past? ___ Yes ___ No If **Yes**, provide the following information concerning past treatments.

Doctor's Name	Doctor's Specialty	Telephone ( ) Fax ( )
Doctor's Address		Date(s) you were seen by this doctor From _____ To _____
Name of Hospital	Department of Treatment	Telephone ( ) Fax ( )
Hospital's Address		Date(s) you were treated at the hospital From _____ To _____

F. Information About Other Income Benefits (Check all benefits you are receiving or are eligible to receive.)

Source of Income	Amount	Weekly / Monthly	Date claim was filed	Date payments began	Date payments ended
Social Security Retirement	_____	_____	_____	_____	_____
Social Security Disability	_____	_____	_____	_____	_____
Canadian Pension Plan	_____	_____	_____	_____	_____
Workers' Compensation	_____	_____	_____	_____	_____
State Disability	_____	_____	_____	_____	_____
Pension Retirement	_____	_____	_____	_____	_____
Pension Disability	_____	_____	_____	_____	_____
Short Term Disability	_____	_____	_____	_____	_____
Unemployment	_____	_____	_____	_____	_____
No-Fault Insurance	_____	_____	_____	_____	_____
Other (include Individual or Group benefits)	_____	_____	_____	_____	_____

G. Information For Tax Withholding

If your request for benefits is approved, should Mutual of Omaha / United of Omaha withhold income taxes from your benefit checks? ___ Yes ___ No

If yes, how much should be withheld from each check (the minimum is **$87.00** per month). $_____.00

H. Signature (Required for all claims.)

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.

The above statements are true and complete to the best of my knowledge and belief.

X _____ _____

Signature of Employee Date

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Education, Training and Work Experience

Name _____

Policy No. _____ Claim No. _____

Educational Background

High School Graduate ___ Yes ___ No If **No**, what was the last grade completed _____ Last date attended _____

GED ____ Yes ____ No Field of Study ____ General ____ Business ____ Vocational ____ Other

Did you attend college? ____ Yes ____ No _____ Last Date Attended? _____

Name and Address of College: _____

_____

Major(s): _____

Final Status: ___ Freshman ___ Sophomore ___ Junior ___ Senior ___ Undergraduate Degree ___ Graduate School

Degree(s) earned: _____

Other formal training: _____

Certification(s): _____

Computer Skills: _____

Military Service ___ Yes ___ No If **Yes**, in which branch did you serve?

Rank: _____

Specialty: _____

What computer programs are you able to use? _____

List all languages spoken fluently: _____

Work Experience

Please fill out completely. Start with your most recent employment and list chronologically.

Dates: From _____ To_____

Employer: _____

Job Title: _____

List job duties: _____

List physical Requirements of job: _____

Product/service produced: _____

Did you supervise others? ____ Yes ____ No

Reason for leaving?_____ _____

Dates: From _____ To_____

Employer: _____

Job Title: _____

List job duties: _____

List physical Requirements of job: _____

Product/service produced: _____

Did you supervise others? ____ Yes ____ No

Reason for leaving?_____ _____

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Dates: From _____ To_____

Employer: _____

Job Title: _____

List job duties: _____

List physical requirements of job: _____

Product/service produced: _____

Did you supervise others? ____ Yes ____ No

Reason for leaving? _____

Dates: From _____ To_____

Employer: _____

Job Title: _____

List job duties: _____

List physical requirements of job: _____

Product/service produced: _____

Did you supervise others? ____ Yes ____ No

Reason for leaving? _____

Dates: From _____ To_____

Employer: _____

Job Title: _____

List job duties: _____

List physical requirements of job: _____

Product/service produced: _____

Did you supervise others? ____ Yes ____ No

Reason for leaving? _____

Additional courses taken, hobbies and special skills. Please be specific such as computer skills either personal or professional, sales, carpentry, auto repair, etc.

_____

_____

Are you currently involved in a vocational rehabilitation program? ____ Yes ____ No

If yes, please provide the name, address and phone # of the rehabilitation case worker_____

_____

Are you interested in learning about our vocational rehabilitation program? _____Yes_____ No

What is your employment goal or other work that you would be interested in doing?

Date: _____ **Signature:** _____

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Authorization to Disclose Personal Information

1. I authorize any physician, medical or dental practitioner, hospital, clinic, pharmacy, benefit manager, other medical care facility, health maintenance organization, insurer, employer, consumer reporting agency and any other provider of medical or dental services to release records containing the personal information of:

Claimant / Patient Name: _____ _____ _____
(Last) (First) (Middle)

2. Personal information includes medical history, mental and physical condition, prescription drug records, alcohol or drug use, and financial and occupational information.

3. You may release information to:

Group Disability Management Services
Mutual of Omaha Insurance Company / United of Omaha Life Insurance Company
Mutual of Omaha Plaza
Omaha, NE 68175 – 0001
or
Fax: 402 - 997-1865

4. I understand that the personal information that is disclosed will be used only by Mutual of Omaha Insurance Company and United of Life Omaha Insurance Company to evaluate my claim for disability benefit plan reimbursement and that if I refuse to sign this authorization my claim for benefits may not be paid.

5. I understand that if the person or entity to whom information is disclosed is not a health care provider or health plan subject to federal privacy regulations, the personal information may be re-disclosed without the protection of the federal privacy regulations.

6. This authorization will expire 24 months after the date it is signed.

7. I understand that I may revoke this authorization at any time by providing a written request to Mutual of Omaha Insurance Company and United of Omaha Life Insurance Company at the above address. If I revoke this authorization, it will not affect any use or disclose of personal information that occurred prior to the insurer's receipt of my revocation.

8. I understand that I am entitled to receive a copy of this authorization and that a copy is as valid as the original.

Name(s) used for records (if different than the name below): _____

_____

_____ _____
Signature of Claimant Date

If applicable: I am the legal representative of the claimant and I am authorized to grant permission on behalf of the claimant.
Printed name of Legal Representative: _____
Signature of Legal Representative: _____
Type of Legal Representative: _____

THIS AUTHORIZATION COMPLIES WITH HIPAA AND OTHER FEDERAL AND STATE LAWS

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Section 2 – Employer's Statement (Answer all questions to avoid delay.)

Employee's Name and Address	Social Security Number	Date of Birth

A. Information About the Employer

Company's Name	Group Policy Number	Class No. or Description

Company's Address (Number, Street, City, State, Zip)	Company's Telephone ( ) Company's Fax ( )

Name and Address of Location Where Employee Works	Location No.	Location Telephone ( ) Location Fax ( )

B. Information About Employee

Employee's Hire Date	Date Employee became insured under this plan: Date Employee became insured under prior plan:	No. of hours Employee regularly works per day / per week? ____ # of hours per/week ____ # of hours per/day

C. Information For Tax Withholding

If this section is left blank, we will calculate FICA taxes based on the following assumption: 100% Employer contribution or any portion paid by Employee is paid with pre-tax dollars

Does Employee contribute post-tax dollars toward the premium? ___ Yes ___ No If so, what percent is paid by Employee? ___ % Post-Tax

D. Information About the Claim

Before Employee became fully disabled, were changes made to Employee's job responsibilities due to the disabling condition? ___ Yes ___ No

If yes, please describe the changes and when they were made.

Date Employee Last Worked	Did Employee work a full day? ___ Yes ___ No If **No**, how many hours were worked?

What was Employee's permanent job on his/her last day worked?	How long had Employee been in this job?

Why did Employee stop working?	Has Employee returned to work? ___ Yes ___ No If **Yes**, when?

Is Employee's condition work related? ___ Yes ___ No	Has a Workers' Compensation claim been filed? ___ Yes ___ No If **Yes**, send initial report of illness/injury and award notice

Name of Workers' Comp Carrier	Address of Workers' Comp Carrier	Contact Person's Name & Phone No.

Name and Address of Medical Insurance Carrier	Is Employee covered under a Group Life policy with Mutual of Omaha? ___ Yes ___ No

E. Information For Life Waiver

Important Notice: If an Employee is age 60 or over, please refer to the policy provisions regarding group life continuation and conversion rights.

Is Employee covered under a Group Life policy with United of Omaha? ___ Yes ___ No If yes, what is the effective date of the life insurance plan?

What is Employee's annual salary?	Amount of Life insurance as of last day worked?

Master Policy Number?	Class	Location

Date Life insurance terminated? If **not** terminated, what is the "paid to date"?	Name of beneficiary (per your records)? Relationship to Employee?

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F. Information About Your Pension Plan (Do not complete for maternity.)

Do you have a pension plan? ___ Yes ___ No | If yes, what type? ___ Defined Benefit ___ 401(k) ___ Other (specify) ___ Defined Contribution ___ Profit Sharing

Is Employee eligible for your pension plan? ___ Yes ___ No | If eligible, does Employee participate? ___ Yes ___ No

If **Yes**, when is Employee eligible for benefits under the pension plan?

If Employee is eligible but does not participate, explain why.

G. Information About Your Rehire or Return to Work Policies

Does your company have a rehire or return to work policy for disabled Employees? ___ Yes ___ No

Who should we contact if we identify a rehabilitation or return to work option? Name/Title:
Contact No.

H. Information About Employee's Salary (Please attach supporting payroll documentation.)

(Check all that apply) Employee ___ is paid hourly ($ hourly rate) ___ is salaried ___ receives commissions ___ receives bonuses

Will Employee file for disability benefits provided by any Employer/Employee Labor Management, State Disability or Union Welfare plan? ___ Yes ___ No

If **Yes**, please answer the following questions. Weekly amount? Date benefits begin? Date benefits end?

Is Employee eligible for Salary Continuation? ___ Yes ___ No If **Yes**, please answer the following questions.

Weekly Amount? Date benefits begin? Date benefits end?

Is Employee eligible for Sick Leave? ___ Yes ___ No If **Yes**, please answer the following questions.

Weekly Amount? Date benefits begin? Date benefits end?

Per the definition of Basic Monthly Earnings in your Policy, what are Employee's pre-disability monthly earnings?

Section 3 - Job Analysis (To be completed by the Employee's Supervisor or HR Department. Answer all questions to avoid delay.)

A. Information About Employee's Job

Job Title	Minimum education or training required?	How long will Employee's job be held open?

Does Employee perform supervisory functions? ___ Yes ___ No If yes, how many people are supervised?

Describe Employee's job duties

Indicate how each of the following relates to Employee's job.

	Occasionally (0%-33%)	Frequently (34%-66%)	Continuously (67%-100%)
Computer Use	___	___	___
Relate to others	___	___	___
Written and verbal communication	___	___	___
Reasoning, math and language	___	___	___
Make independent judgments	___	___	___

Which of the following describe Employee's working environment? **Check all that apply.**

___ Unprotected heights ___ Changes in temperature ___ Exposure to dust, fumes and gases

___ Being near moving machinery ___ Driving automotive equipment ___ Other hazards (please explain)

Is Employee required to travel? ___ Yes ___ No If **Yes**, please answer the following questions.

How does Employee travel? ___ Automobile ___ Plane ___ Train ___ Other

What percent of the time does Employee travel?

Where does Employee travel?

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B. Physical Aspects of the Job

Select how each of the following relates to Employee's job.

Activity	Frequency of Occurrence: Occasionally (0%-33%)	Frequently (34%-66%)	Continuously (67%-100%)
___ Standing	___	___	___
___ Walking	___	___	___
___ Sitting	___	___	___
___ Balancing	___	___	___
___ Stooping	___	___	___
___ Kneeling	___	___	___
___ Crouching	___	___	___
___ Crawling	___	___	___
___ Reaching/working overhead	___	___	___
___ Climbing	___	___	___
___ Number of stairs _____	___	___	___
___ Height of ladder _____	___	___	___
___ Pushing	___	___	___
___ Pulling	___	___	___
___ Lifting/Carrying	___	___	___

Please indicate any activities that require lifting, carrying, pushing or pulling. In addition, specify the weight involved with this activity.

Describe Activity	Weight
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Can alternating sitting and standing activity help Employee perform the job?

___ Yes ___ No

Does the job require use of the feet to operate foot controls? ___ Yes ___ No If **Yes**, list type of equipment.

How important is good vision in the job?

List the major tasks which require the use of one or both hands.	One Hand	Both Hands
_____	___	___
_____	___	___
_____	___	___

Can the job be modified to accommodate the disability either temporarily or permanently? ___ Yes ___ No If **Yes**, explain.

Is it possible to offer Employee assistance in doing the job (e.g. use of technology or personal assistance)? ___ Yes ___ No If **Yes**, explain.

Section 4 – Employer's Signature and Attachments (Please Attach Employee's job description and additional documentation.)

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

Name of person completing this form: _____

Title: _____ Email Address: _____

Telephone: ( ) _____ Fax: ( ) _____

Signature: _____ Date: _____

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Section 5 – Physician's Statement (Answer all questions to avoid delay.)

A. General Information

Patient's Name:	Employer's Name:	Policy Number:

Patient's Social Security Number:	Height:	Weight:	Blood Pressure:	Date of Birth:

B. Complete the following for normal pregnancy, then go to Section E.

Date of the patient's last menstrual period?	Expected date of delivery?

Expected length of postpartum recovery?	First date of treatment?	Last date of treatment?

C. Complete the following for all conditions except normal pregnancy.

Primary diagnosis (including ICD-9 or DSM code)	Symptoms

What diagnostic testing has been done?	Objective Findings

Are there secondary conditions contributing to the patient's disability? ___ Yes ___ No
If **Yes**, what are they (include ICD-9 or DSM)?

If this is a cardiac condition, what is the functional capacity (American Heart Association)? ___ Ejection Fraction ___ Class 1-No Limitation
___ Class 2-Slight Limitation ___ Class 3-Marked Limitation ___ Complete Limitation

If this is a psychiatric condition, what is the current GAF score?	In the past year, what was the patient's highest GAF score?

When did symptoms first appear?	Date of patient's first visit?	Date patient was first unable to work?

Date of patient's last visit?	How often do you see this patient?

Is the patient's condition work related? ___ Yes ___ No If **Yes**, please explain.

Has patient undergone surgery or expected to have surgery in the future? ___ Yes ___ No If **Yes**, answer the following.
Date of surgery: Surgical Procedure? Result:

What medication is the patient currently taking or been prescribed?

Please indicate other types and frequencies of treatment.

Has the patient been referred to a medical rehabilitation or therapy program? ___ Yes ___ No If **Yes**, give details.

Have you referred the patient for other types of consultations? ___ Yes ___ No If **Yes**, give details.

Has the patient been hospital confined? ___ Yes ___ No If **Yes**, please complete the following.

Name of Hospital	Address of Hospital	Dates of Confinement
		From _____ To _____

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D. Information about the patient's inability to work

Briefly describe the patient's restrictions. (SHOULD NOT DO)

Briefly describe the patient's limitations. (CANNOT DO)

What is your prognosis for recovery?

Has patient achieved maximum medical improvement? ___ Yes ___ No If **No**, please complete the following.

How soon do you expect fundamental changes in the patient's medical condition?

___ 1-2 months ___ 5-6 months ___ 1 year or more

___ 3-4 months ___ 6 months to a year ___ Never

Give details concerning expected improvement or deterioration.

What is your treatment plan for the patient's return to work or return to prior level of function?

In an eight-hour workday, the patient can: **(Circle full hourly capacity for <u>each</u> activity)**

Sit	1	2	3	4	5	6	7	8
Stand	1	2	3	4	5	6	7	8
Walk	1	2	3	4	5	6	7	8

Are there restrictions in:	Yes	No	If **Yes**, please fully explain below.
Driving/Operating motorized equipment	___	___	_____
Lifting / Carrying	___	___	_____
Use of hands in repetitive actions	___	___	_____
Use of feet in repetitive movements	___	___	_____
Bending	___	___	_____
Squatting	___	___	_____
Crawling	___	___	_____
Climbing	___	___	_____
Reaching above shoulder level	___	___	_____
Other	___	___	_____

When do you expect the patient to return to prior level of functioning?

Would you recommend vocational rehabilitation for this patient? ___ Yes ___ No

E. Required Attachments and Signature

After you have fully completed this form, please attach copies of the following materials.

- Office notes for the period of treatment received over the last two years
- Test results showing objective findings
- Hospital discharge summaries
- Consulting physician reportss

Your Name | Degree

Specialty | Telephone No. ( ) Fax No. ( )

Address

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.

x _____ _____

Signature of Attending Physician (no stamp) Date