

Attending Physician's Statement of Disability

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company submits an insurance application or statement of claim containing any false, incomplete, or misleading information may be subject to civil or criminal penalties, depending upon the state law. In Florida, this is a felony of the third degree.

PATIENT'S NAME (please print)	DATE OF BIRTH
PRESENT ADDRESS (NUMBER & STREET)	SOCIAL SECURITY NUMBER
(CITY, STATE, ZIP)	GROUP POLICY NUMBER
NAME OF PATIENTS EMPLOYER:	

Attending Physician's Statement of Disability

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

HISTORY

1

(a) When did symptoms first appear or accident happen?	Month	Day	Year
(b) Date disability commenced:	Month	Day	Year
(c) Please submit copies of all office notes since disability commenced.			
(d) Has the patient ever had the same or similar condition?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
If, "Yes", state when and describe:			
(e) Is condition due to injury or sickness arising out of patient's employment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown

DIAGNOSIS (including any complications)

2

(a) Date of last examination	Month	Day	Year
(b) Diagnosis (including any complications)			
(c) Subjective symptoms			
(d) Objective findings (including current X-rays, EKG's, Laboratory Data and any clinical findings)			

DATES OF TREATMENT

3

(a) Date of first visit	Month	Day	Year
(b) Date of last visit	Month	Day	Year
(c) Frequency	<input type="checkbox"/> Weekly	<input type="checkbox"/> Monthly	Other, specify:

NATURE OF TREATMENT

4

Including Surgery and medications prescribed, if any:			
Will treatment substantially improve function and employability?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
If "Yes" specify:			

(over)

PROGRESS**5**

(a) Has patient	<input type="checkbox"/> Recovered?	<input type="checkbox"/> Improved?	<input type="checkbox"/> Unchanged?	<input type="checkbox"/> Retrogressed?
(b) Is patient	<input type="checkbox"/> Bed confined?	<input type="checkbox"/> Hospital Confined?	<input type="checkbox"/> Ambulatory?	<input type="checkbox"/> House confined?
(c) Has the patient been hospital confined?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
If "Yes", give name and address of hospital:			Confined from	through

CARDIAC (if applicable)**6**

(a) Functional capacity (American Heart Assoc.)	<input type="checkbox"/> Class 1 (no limitation)	<input type="checkbox"/> Class 2 (slight limitation)
	<input type="checkbox"/> Class 3 (marked limitation)	<input type="checkbox"/> Class 4 (Complete limitation)
(b) Blood Pressure (last visit)	Systolic	Diastolic

LIMITATION (number of hours in a work day able to perform)**7**

Standing	Climbing	Bending	Use of Hands	Sitting
Walking	Stopping	Lifting	Other (please describe):	

PHYSICAL IMPAIRMENT (as defined in Federal Dictionary of Occupational Titles)**8**

<input type="checkbox"/> Class 1	- No limitation of function 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:	

MENTAL/NERVOUS IMPAIRMENT (if applicable)**9**

Please define "stress" as it applies to this claimant.

<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 the proceeds thereof? <input type="checkbox"/> Yes <input type="checkbox"/> No	

EXTENT OF DISABILITY**10**

(a) Is patient now totally disabled?	From Any Occupation			From Patient's Regular Occupation		
	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No		
(b) If no, when is patient able to go to work?	Mo.	Day	Year	Mo.	Day	Year
(c) If yes, when do you think patient will be able to resume any work?	Mo.	Day	Year	Mo.	Day	Year
	Indefinite:	<input type="checkbox"/>		<input type="checkbox"/>		
	Never:	<input type="checkbox"/>		<input type="checkbox"/>		

REHABILITATION**11**

(a) Is patient a suitable candidate for further rehabilitation services?	<input type="checkbox"/> Yes <input type="checkbox"/> No					
(b) Can present job be modified to allow for handling with impairment?	<input type="checkbox"/> Yes <input type="checkbox"/> No					
(c) When could trial employment commence?	Patient's Job			Any Other Work		
	Mo.	Day	Year	Mo.	Day	Year
	<input type="checkbox"/> Full-Time		<input type="checkbox"/> Part-Time	<input type="checkbox"/> Full-Time		<input type="checkbox"/> Part-Time
(d) Would vocational counseling and/or retraining be recommended?	<input type="checkbox"/> Yes <input type="checkbox"/> No					

Remarks:**12**

(a) Functional capacity (American Heart Assoc.)

Date:	Signature (attending physician)	Degree	Telephone
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Address (street, city or town, state or Province, Zip Code)

**Please return this form to: ASRM Claims Department
509 South Lenola Road, Building Two
Moorestown, NJ 08057**