Disability Claim Filing Instructions

Have you...

1. Completed the Employee's Statement (pages 4 through 5) in full?
2. Had the physician treating you complete the Attending Physician’s Statement (pages 8 through 9), and had it returned to you?
3. Had your Employer complete the Employer's Statement (page 7), and had it returned to you?
4. Read, signed and dated the Authorization for Release of Information (page 6)?

Submit the completed statements to the address below or fax to (207) 591-3048.

All portions of these forms must be completed in order to expedite your claim.

If you have any questions when completing this form, please call:

Toll-Free Phone Number 1-866-258-8743

CMFG Life Insurance Company
c/o Disability RMS
One Riverfront Plaza
Westbrook, ME 04092-9700
Facts You Should Know

This information is intended to provide highlights of your disability plan insured by CMFG Life Insurance Company. This document does not constitute a contract. Refer to your disability certificate for complete details or call CMFG Life Insurance Company’s Employee Benefits Customer Service area at 1-800-548-9390 whenever you have questions concerning your disability benefits.

FILING YOUR CLAIM
Frequently the initial claim form that needs to be submitted is incomplete. To expedite the processing of your claim, please provide a copy of your office and treatment notes, test results, hospital admit/discharge notes if appropriate, and consulting physician reports (flowchart for maternity claims).

ELIMINATION/WAITING PERIOD
The elimination/waiting period is the number of calendar days you must be disabled before benefits begin. This can be a combination of partial and total disability. No benefits are paid during this period. Your certificate shows the elimination/waiting period chosen by your employer. You must be receiving care and treatment by a physician qualified to treat your condition during this period.

WHEN BENEFITS ARE PAID
If approved, disability benefits will begin following completion of your elimination/waiting period. Payments are made in arrears. For example, if you are disabled for the entire month of January, the January benefit payment will be mailed to you around the first of February.

BENEFIT PAID
Your employer has chosen a percentage (i.e. 60%) of pre-disability monthly salary or a flat dollar amount for your disability benefit. This is the benefit you will receive when you become disabled (less FICA and any other income benefits). Refer to the disability schedule in your certificate for the benefit option chosen by your employer. If you want to have Federal Income Tax withheld from your benefit, you must complete Form W-4S. The form can be located on the website www.irs.ustreas.gov or by requesting a form from Disability RMS at 1-866-258-8743.

REDUCTION (OFFSET) IN BENEFITS
Disability benefits will be reduced (offset) if you are eligible for OR you are receiving other income benefits as defined by the Certificate. Refer to the Other Income Benefits section in your certificate.

Your disability benefits are reduced dollar for dollar by the benefits received from other sources such as:

- sick leave
- any other group insurance disability plan
- state disability plan
- social security disability benefits (primary and/or family)
- workers compensation
- earnings earned or received from any form of employment including, but not limited to, vacation, holiday pay, personal leave and funeral leave
- withdrawals from pension plan

For example, if you receive sick leave pay after your elimination/waiting period has ended, we will deduct (offset) that payment from your disability benefit payment.

Amounts which your spouse or dependent children become entitled to as a result of your disability may also be offset from your disability benefit if your Certificate specifies primary and family offsets.
**RIGHT OF RECOVERY**
If you are awarded Social Security, Worker's Compensation or any other income for this same disabling condition, you must notify us immediately. If disability benefits have been overpaid on your claim, you will be required to reimburse us within 60 days or we may reduce future benefits until we are fully reimbursed. If you fail to provide the overpayment when requested, your claim may be referred to a collection or recovery agency.

You must cooperate with us in any effort to recover from others for the lost income. You must notify us immediately of any claim or settlement and must do nothing to prejudice our rights or interests.

**MATERNITY**
Unless complications of your pregnancy have precluded you from performing your normal occupational duties, disability benefits for maternity begin from the date of delivery. Based on medical guidelines, a normal period of disability for maternity extends four to six weeks postpartum for a vaginal delivery and six to eight weeks postpartum for a cesarean section delivery. Remember, no benefits are paid during the elimination/waiting period. Complications of pregnancy and/or delivery will be handled on a case-by-case basis and additional medical documentation will be required.

Following are examples of Short Term and Long Term disability benefits for a non-complicated pregnancy with vaginal delivery:

<table>
<thead>
<tr>
<th>Date of delivery</th>
<th>Short Term*</th>
<th>Long Term*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elimination/waiting period:</td>
<td>7 days*</td>
<td>30 days*</td>
</tr>
<tr>
<td>Date benefits begin:</td>
<td>3/22</td>
<td>4/14</td>
</tr>
<tr>
<td>Date benefits end:</td>
<td>4/11 (3 weeks payable)</td>
<td>4/11 (benefits not payable)</td>
</tr>
</tbody>
</table>
- 4 weeks | 4/18 (4 weeks payable) | 4/18 (5 days payable) |
- 5 weeks | 4/25 (5 weeks payable) | 4/25 (12 days payable) |

(*Please note: the coverage type and elimination period may vary from employer to employer; please verify your coverage with your employer or with CUNA Mutual Group for specific details)

**REHABILITATION**
Your case may be referred to an outside rehabilitation vendor and/or agency for assistance in gathering needed information from you, your employer, your physician and other care providers.

If appropriate and approved by your treating physician or appropriate medical consultant and us, you will be required to participate in a rehabilitation program. You may be assigned to work with a rehabilitation specialist. Rehabilitation may consist of, but not be limited to, transferable skills analysis, labor market survey, job placement activity, job skills training, work hardening, transitional return to work, and light duty work.

You may receive adjusted benefits if you qualify and engage in rehabilitative work. To qualify for the adjusted benefits, you must provide us with proof of your earnings, on a monthly basis, and you must be working for pay or profit under a rehabilitation program approved by your treating physician or appropriate medical consultants and us. If you are working in a job not approved under your rehabilitation program, whether for pay or not, your benefits may be terminated.

This information is intended to provide highlights of your disability plan insured by CMFG Life Insurance Company. This document does not constitute a contract. Refer to your disability certificate for complete details or call CMFG Life Insurance Company’s Employee Benefits Customer Service area at 1-800-548-9390 whenever you have questions concerning your disability benefits.
## Employee's Statement

(All questions must be answered to avoid delay.)

### Your Name

<table>
<thead>
<tr>
<th>Your Name</th>
<th>Your Social Security Number</th>
</tr>
</thead>
</table>

### Your Address

<table>
<thead>
<tr>
<th>Street &amp; No.</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
</tr>
</thead>
</table>

### Telephone Number

<table>
<thead>
<tr>
<th>Number</th>
<th>-</th>
</tr>
</thead>
</table>

### Date of Birth

<table>
<thead>
<tr>
<th>/</th>
<th>/</th>
</tr>
</thead>
</table>

### Marital Status

- Married
- Divorced
- Single
- Widowed

### Number of Dependent Children

- Yes
- No

### Gross Annual Salary

- (in effect immediately prior to your disability - for this employer only)
- $ _________________

### Effective Date of Salary

| __________ |

### Employer's Telephone Number

| ( ) | - |

### Employer's Address

<table>
<thead>
<tr>
<th>Street &amp; No.</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
</tr>
</thead>
</table>

### My Occupation & Title

- List essential duties of my job at the time of disability

### Date of Injury or Date First Noticed Symptoms of Sickness

| / | / |

### I Have Been Unable to Work Because of Disability Since

| / | / |

### I Returned to Work on a Part-Time Basis On

| / | / |

### I Returned to Work on a Full-Time Basis On

| / | / |

### Is My Injuries or Sickness Related to My Occupation?

- Yes
- No

### Did I File for Workers' Compensation?

- Yes
- No

### Describe How and Where Injury Occurred or Describe the Onset and Nature of My Medical Condition Including Symptoms. If More Space Is Needed, Please Attach Sheet of Paper.

### Date First Treated

| / | / |

### Treated By

- Hospital
- Doctor

### I Have Ever Had the Same or Similar Condition in the Past?

- Yes
- No

### Employee/Claimant must complete Pages 4 through 6 of this form.
FOR PREGNANCY DISABILITY ONLY:
Are there any present complications or difficulties in connection with:

a. Pregnancy □ YES □ NO Date of last menstrual period: ___________ Expected date of delivery ___________

b. Delivery □ YES □ NO Actual date of delivery: ___________ □ Vaginal □ C-Section

c. Post Partum □ YES □ NO

If "YES" to any of these, please specify in detail: __________________________________________________________

As a result of this disability, am I, my spouse or any of my dependent children receiving income from any of the following:

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
<th>TYPE</th>
<th>AMOUNT</th>
<th>DATE BEGAN</th>
<th>DATE TERM</th>
<th>PAID WEEKLY</th>
<th>PAID MONTHLY</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Sick, Vacation, Personal, PTO, etc.</td>
<td>$_________</td>
<td>___________</td>
<td>__________</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Salary Continuance Benefits?</td>
<td>$_________</td>
<td>___________</td>
<td>__________</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Workers’ Compensation?</td>
<td>$_________</td>
<td>___________</td>
<td>__________</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Local, State, or National Association or Society Disability Income Plan?</td>
<td>$_________</td>
<td>___________</td>
<td>__________</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>No Fault Motor Vehicle Plan?</td>
<td>$_________</td>
<td>___________</td>
<td>__________</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Unemployment Compensation?</td>
<td>$_________</td>
<td>___________</td>
<td>__________</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Social Security Benefits (disability or retirement)?</td>
<td>$_________</td>
<td>___________</td>
<td>__________</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Retirement Income (normal, early, or disability)?</td>
<td>$_________</td>
<td>___________</td>
<td>__________</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Other STD/LTD Benefits?</td>
<td>$_________</td>
<td>___________</td>
<td>__________</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Other? (describe)</td>
<td>$_________</td>
<td>___________</td>
<td>__________</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

HAVE I APPLIED, OR DO I PLAN TO APPLY FOR BENEFITS DESCRIBED ABOVE? □ YES □ NO

TYPE ___________ DATE APPLICATION FILED ___________

IF MY REQUEST FOR BENEFITS IS APPROVED, DO I WANT INSURER TO WITHHOLD FEDERAL INCOME TAXES? □ YES □ NO

INDICATE AMOUNT: $ __________________  ($88 MINIMUM PER MONTH)

FRAUD NOTICE

Unless specific state language is provided below, and unless you reside in Virginia, the following general fraud notice applies: 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.

Arizona – For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Arkansas, Louisiana, New Mexico, West Virginia - 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.

California - For your protection California law requires the following statement to appear on this form: “Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of an offense and may be subject to fines and confinement in state prison.”

Delaware, Florida, Idaho, Indiana, Oklahoma - Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

District of Columbia, Colorado – 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.

Kentucky – Any person who knowingly and with intent to defraud any insurance company or other person files 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 – It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

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

New Hampshire - Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

New Jersey - Any person who knowingly files a statement of claim containing any false or misleading information is subject to civil or 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.

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.

Signature of Employee __________________________________________________________ Date ________________

Employee/Claimant must complete Pages 4 through 6 of this form.
AUTHORIZATION FOR RELEASE OF INFORMATION (excluding psychotherapy notes)
(pursuant to HIPAA privacy rules and state law)
(to be signed and dated by the insured/claimant)

I authorize any licensed physician, any other medical practitioner or provider, pharmacist, hospital, clinic, other medical or medically related facility, federal, state or local government agency, insurance or reinsuring company, the Social Security Administration, consumer reporting agency or employer having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me, and any non-medical information about me (including any information, data or records regarding my Social Security, FICA earnings history, Worker’s Compensation, State Disability, pension, credit, earnings and employment history) to give any and all such information to authorized representatives of Disability Reinsurance Management Services, Inc. (Disability RMS), and CMFG Life Insurance Company excluding psychotherapy notes, and including, but not limited to, any other mental or psychiatric records, medical, dental and hospital records (including psychiatric, alcohol, and drug abuse, and HIV/AIDS* information). I understand that the information obtained by use of this authorization will be used by Disability RMS, CMFG Life Insurance Company and the above-described representatives to evaluate and adjudicate my current disability claim, and may be re-disclosed to (a) any medical, investigative, financial or vocational specialist or entity, or (b) any other organization or person, employed by or representing Disability RMS or CMFG Life Insurance Company to assist with the evaluation and adjudication of my current disability claim and/or to report aggregate claims information to CMFG Life Insurance Company. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by the privacy rules issued pursuant to HIPAA, or any other federal or state law.

This authorization is valid for two (2) years following the date of my signature. A photocopy of this authorization is as valid as the original. I understand that my authorized representative or I have the right to request and receive a copy of this authorization, and to inspect or copy, for a reasonable fee, the information to which it pertains.

I understand that I have the right to revoke this authorization by notifying Disability RMS in writing, of my revocation. However, such revocation is not effective to the extent that Disability RMS and/or CMFG Life Insurance Company have relied previously upon this authorization for the use or disclosure of my protected health information. I understand that CMFG Life Insurance Company cannot condition the payment of a claim on my signing this authorization. However, I understand that my revocation of, or my failure to sign this authorization may impair Disability RMS’ and CMFG Life Insurance Company’s ability to evaluate my current disability claim and as a result lack of required information may be a basis for denying that current disability claim for benefits.

*If you reside in California: This authorization excludes the release of Human Immunodeficiency Virus (HIV) and Autoimmune Deficiency Disorder (AIDS) information and test results. Separate authorizations signed by the insured claimant, or employee-claimant (for self-insured business) are required each time results are released.

*If you reside in Connecticut, Maine or Massachusetts: This authorization excludes the release of information about Human Immunodeficiency Virus (HIV) and Autoimmune Deficiency Disorder (AIDS). Separate authorizations signed by the insured claimant, or employee-claimant (for self-insured business) are required each time results are released.

*If you reside in Vermont: This authorization EXCLUDES the release of any information about previously administered HIV-related tests, including but not limited to tests for HIV antibodies, T-Cell counts, AIDS or ARC. The proposed insured is NOT AUTHORIZING Disability RMS to forward the results from any new test, requested by us, to any outside, non-affiliated company or entity not under specific contract with us to perform underwriting services, and Disability RMS shall comply, as applicable, with the provisions of Title 8, Section 4724 (20) of the Vermont Statutes.

Claimant Signature (or Authorized Representative)__________________________________   Date:  __________

Description of Personal Representative’s Authority (if applicable):
(If signed by authorized representative, attach verification of identity)

Employee/Claimant must complete Pages 4 through 6 of this form.
CMFG Life Insurance Company
For Claim Filing Questions - Phone: 1-866-258-8743
Fax Completed Claim Form to: (207) 591-3048
Mail to: c/o Disability RMS
One Riverfront Plaza
Westbrook, ME 04092-9700

NOTICE OF CLAIM FOR
☐ SHORT TERM DISABILITY BENEFITS
☐ LONG TERM DISABILITY BENEFITS
☐ GROUP LIFE PREMIUM WAIVER
Contract Number: ________________

Employer must complete Page 7 of this form and return form to the Employee.

---

### EMPLOYER’S OR ADMINISTRATOR’S STATEMENT

**NAME OF EMPLOYEE**

<table>
<thead>
<tr>
<th>OCCUPATION</th>
<th>IS DISABILITY DUE TO EMPLOYMENT?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☐ YES ☐ NO</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DATE EMPLOYED /</th>
<th>DATE INSURED /</th>
<th>DATE LAST WORKED /</th>
<th>REASON FOR STOPPING WORK /</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>☐ Resigned ☐ Layoff ☐ Disability ☐ Dismissed</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>☐ Family Medical Leave of Absence ☐ Other Leave of Absence</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DATE RETURNED TO WORK /</th>
<th>IF PART-TIME, NUMBER OF HOURS WORKED PER WEEK /</th>
<th>IF EMPLOYEE HAS NOT RETURNED TO WORK, ESTIMATED RETURN TO WORK DATE: /</th>
<th>DATE EMPLOYMENT TERMINATED /</th>
<th>DATE DISABILITY INSURANCE TERMINATED /</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>REQUIRED NUMBER OF HRS. PER WEEK /</th>
<th>GROSS SALARY: (in effect immediately prior to your employee’s disability) $</th>
<th>PLEASE INDICATE HOW THE EMPLOYEE IS PAID:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☐ Hourly Rate ☐ Weekly ☐ Monthly ☐ Yearly ☐ Commissions</td>
<td>☐ 9 MOS./YR. ☐ 10 MOS./YR. ☐ 12 MOS./YR. ☐ OTHER</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>IS EMPLOYEE SUBJECT TO FICA TAX?</th>
<th>☐ YES ☐ NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>IF &quot;YES&quot;, IS EMPLOYEE SUBJECT TO FULL FICA TAX? ☐ YES ☐ NO</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PERCENTAGE OF EMPLOYEE/EMPLOYER CONTRIBUTION TO PREMIUM FOR THIS DISABILITY PLAN (AS OF POLICY YEAR OF DISABILITY)</th>
<th>☐ 100% ☐ OTHER ___________%</th>
</tr>
</thead>
<tbody>
<tr>
<td>EMPLOYEE ☐ 100% ☐ OTHER ___________% IS EMPLOYEE CONTRIBUTION: ☐ PRE-TAX DEDUCTION? ☐ AFTER-TAX DEDUCTION?</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>IS EMPLOYEE ELIGIBLE FOR:</th>
<th>AMOUNT</th>
<th>DATE BEGAN</th>
<th>DATE TERM</th>
<th>PAID WEEKLY</th>
<th>PAID MONTHLY</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ ☐ Sick, Vacation, Personal, PTO, etc.</td>
<td>$__________</td>
<td>__________</td>
<td>__________</td>
<td>☐ ☐</td>
<td></td>
</tr>
<tr>
<td>☐ ☐ Salary Continuance Benefits?</td>
<td>$__________</td>
<td>__________</td>
<td>__________</td>
<td>☐ ☐</td>
<td></td>
</tr>
<tr>
<td>☐ ☐ Workers’ Compensation?</td>
<td>$__________</td>
<td>__________</td>
<td>__________</td>
<td>☐ ☐</td>
<td></td>
</tr>
<tr>
<td>☐ ☐ Local, State, or National Association or Society Disability Income Plan?</td>
<td>$__________</td>
<td>__________</td>
<td>__________</td>
<td>☐ ☐</td>
<td></td>
</tr>
<tr>
<td>☐ ☐ No Fault Motor Vehicle Plan?</td>
<td>$__________</td>
<td>__________</td>
<td>__________</td>
<td>☐ ☐</td>
<td></td>
</tr>
<tr>
<td>☐ ☐ Unemployment Compensation?</td>
<td>$__________</td>
<td>__________</td>
<td>__________</td>
<td>☐ ☐</td>
<td></td>
</tr>
<tr>
<td>☐ ☐ Social Security Benefits (disability or retirement)?</td>
<td>$__________</td>
<td>__________</td>
<td>__________</td>
<td>☐ ☐</td>
<td></td>
</tr>
<tr>
<td>☐ ☐ Retirement Income (normal, early, or disability)?</td>
<td>$__________</td>
<td>__________</td>
<td>__________</td>
<td>☐ ☐</td>
<td></td>
</tr>
<tr>
<td>☐ ☐ Other STD/LTD Benefits?</td>
<td>$__________</td>
<td>__________</td>
<td>__________</td>
<td>☐ ☐</td>
<td></td>
</tr>
<tr>
<td>☐ ☐ Other? (describe)</td>
<td>$__________</td>
<td>__________</td>
<td>__________</td>
<td>☐ ☐</td>
<td></td>
</tr>
</tbody>
</table>

PLEASE ATTACH A COPY OF THE FOLLOWING DOCUMENTS TO THIS FORM:

- The employee’s Workers’ Compensation claim(s) and Approval/Denial Notification
- The employee’s current job description

Unless you reside in Virginia, the following general fraud notice applies: 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.

I CERTIFY THAT TO THE BEST OF MY KNOWLEDGE THE ABOVE STATEMENTS ARE TRUE AND CORRECT.

---

**NAME OF POLICYHOLDER (COMPANY)**

**PRINT NAME & TITLE OF OFFICIAL REPRESENTATIVE**

**MAILING ADDRESS OF POLICYHOLDER (COMPANY)**

**SIGNATURE**

**DATE**

**TELEPHONE NUMBER**

**FAX NUMBER**

Home Office Use Only:

Premiums paid to: __/__/____ Type: ☐ Occ coverage ☐ Non-occ coverage Prior Coverage ☐ Yes ☐ No If Yes, prior carrier name and telephone number: __________________________

---

Employer’s or Administrator's Statement (All questions must be answered to avoid delay.)
**ATTENDING PHYSICIAN’S STATEMENT** - THIS STATEMENT MUST BE FILLED-IN COMPLETELY BY A PHYSICIAN.

(Please Print or Type)

<table>
<thead>
<tr>
<th>Name of Patient</th>
<th>Male</th>
<th>Date of Birth</th>
<th>Female</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**FIRST**  | **MIDDLE**  | **LAST**  | **Blood Pressure (last visit)** | **Systolic** / **Diastolic** |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. **HISTORY:**
   a. Is condition due to ☐ Accident? ☐ Sickness?
   b. When did symptoms first appear or injury occur? Mo. ___________  Day ___________  Year ___________
   c. Date patient was unable to work because of impairment: Mo. ___________  Day ___________  Year ___________
   d. Has patient ever had same or similar condition? ☐ Yes ☐ No  If "Yes", state when and describe ____________________________
   e. Is condition due to injury or sickness arising out of patient's employment? ☐ Yes ☐ No  Please explain: ____________________________
   f. Was this patient referred to you? ☐ Yes ☐ No  If "Yes", by whom and what is their specialty?
   g. Have you referred this patient to another treating provider? ☐ Yes ☐ No  If "Yes", to whom and what is their specialty?

2. **DIAGNOSIS:**
   a. Diagnosis impacting function: ___________________________________________  ICD9 Code(s) ______________________________
      Nature of treatment (including surgery, LPT code and medications prescribed, if any, including dosage and frequency) ____________________________________________________________________________________________
   b. Secondary diagnosis impacting function:
      Nature of treatment (including surgery, LPT code and medications prescribed, if any, including dosage and frequency) ____________________________________________
   c. Subjective symptoms: _________________________________________________
   d. Objective findings (including current X-rays, EKGs, Laboratory Data and any clinical findings): ________________________________________________

3. **FOR PREGNANCY DISABILITY ONLY:**
   Are there any present complications or anticipated difficulties in connection with:
   a. Pregnancy ☐ YES ☐ NO  Date of last menstrual period: ___________  Expected date of delivery: ___________
   b. Delivery ☐ YES ☐ NO  Actual date of delivery: ___________  ☐ Vaginal ☐ C-Section
   c. Post Partum ☐ YES ☐ NO
   If "YES" to any of these, please specify in detail: ____________________________________________

4. **DATES OF TREATMENT FOR THIS CONDITION:**
   a. Date of first visit Mo. ___________  Day ___________  Year ___________
   b. Date of last visit Mo. ___________  Day ___________  Year ___________
   c. Next office visit Mo. ___________  Day ___________  Year ___________
   d. Frequency ☐ Weekly  ☐ Monthly  ☐ Other (specify) ______________________

5. **PROGRESS:**
   If "Hospital Confined", give Name and Address of Hospital ____________________________________________
   Confined from ___________ through ___________

Attending Physician must complete Pages 8 through 9 of this form and return the form to your Patient/the Employee.
ATTENDING PHYSICIANS SECTION – Page 2

Name of Patient:

6. CARDIAC (if applicable)

<table>
<thead>
<tr>
<th>Functional Capacity</th>
<th>Class 1 (No limitation)</th>
<th>Class 2 (Slight limitation)</th>
<th>Class 3 (Marked limitation)</th>
<th>Class 4 (Complete limitation)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(American Heart Assoc. standards)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

7. CURRENT FUNCTIONAL ABILITY

a. In an 8 hour day, what is the maximum number of hours your patient could perform each of these levels of activity? (please indicate appropriate number of hours):

   ___ Hrs.  Sedentary Activity  10 lbs. maximum lifting or carrying articles. Walking/standing on occasion. Sitting 6 to 8 hours. *
   ___ Hrs.  Light Activity  20 lbs. maximum lifting, carrying 10 lbs. articles frequently, most jobs involving standing with a degree of pushing and pulling. Standing 6 to 8 hours. *
   ___ Hrs.  Medium Activity  50 lbs. maximum lifting with frequent lifting/carrying of up to 25 lbs. Frequent walking and standing. *
   ___ Hrs.  Heavy Activity  100 lbs. maximum lifting, frequent lifting/carrying of up to 50 lbs. Frequent walking and standing. *

b. Please check appropriate box:

   Occasionally (0% to 33%)  Frequently (33% to 66%)  Continuously (66% to 100%)

   Bending  
   Climbing  
   Reaching  
   Kneeling  
   Squatting  
   Crawling  
   Push/pull  
   No. of lbs.  
   Lifting (lbs.)  
   No. of lbs.  
   No. of lbs.  
   No. of lbs.

   What is this assessment based on?  observed activity  measured capacity  physical therapy report

c. Please list current restrictions (activities which should not be performed) and limitations (activities which cannot be performed) from activities not addressed above (i.e. driving, working at heights, etc.) Please be specific.

   ________________________________
   ________________________________
   ________________________________

   d. Upper Extremity Function - Please indicate upper extremity functional capabilities:

   Simple grasp  
   Pinch  
   Fine manipulation  
   Power grip  
   Repetitive motion  

   Left  Right  Comments

   ________________________________
   ________________________________
   ________________________________
   ________________________________

8. MENTAL HEALTH ABILITY (if applicable)

   What behavior, attitudes or functional impairments are contributing to any restrictions and/or limitations related to a mental health condition?

   ________________________________
   ________________________________
   ________________________________

9. RETURN TO WORK PLAN

a. Have you discussed a return to work plan with your patient?  Yes  No
b. The date you released patient to return to work:  ____ / ____ / ____  Full-time  Reduced hours  Number of hours:

   MO.  DAY  YEAR

   ____________
   ____________
   ____________

c. Please identify your recommendations for any job modifications that would enable the patient to work.

   ________________________________
   ________________________________
   ________________________________

Unless you reside in Virginia, the following general fraud notice applies: 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.

ATTENDING PHYSICIAN’S SIGNATURE  DATE

PHYSICIAN’S NAME (PLEASE PRINT)

DEGREE/SPECIALTY

TELEPHONE NUMBER (______)________-_________  FAX NUMBER (_______)_______- __________  TAX ID #

OFFICE ADDRESS

NUMBER/STREET

CITY OR TOWN  STATE  ZIP CODE

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