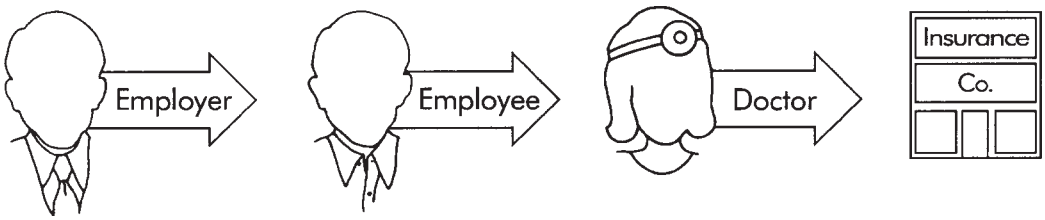
The Lincoln National Life Insurance Company, PO Box 2609, Omaha, NE 68103-2609
toll free (800) 423-2765 Fax (877) 843-3950
www.LincolnFinancial.com

GROUP LONG-TERM DISABILITY CLAIM
(PLEASE see FRAUD NOTICES attached)

EMPLOYER: CITY OF MILWAUKEE

GROUP POLICY NO.: 000010178968



EMPLOYER - form completion information

NOTICE OF CLAIM - Instructions

A. **Complete** the **employer's portion in full** and **return this portion** to address above or fax to the number above

Include
- Copy of enrollment card (if employee contributes to premium)
- Copy of approved medical evidence of insurability if required at time of enrollment
- If Workers' Compensation claim filed, include copy of First Report of Accident and the decision

B. **Give remaining part of form to claimant for completion**

Long-Term Disability Claim Employer's Statement

DO NOT complete sections highlighted in yellow.

To Be Completed By The Employer

This claim is for (Employee's Name and Address)	Social Security Number	Date of Birth

A. Information about the employer

Company's Name	Group Policy Number	Class Number
CITY OF MILWAUKEE	000010178968	
Address (Street, City, State, Zip)	Telephone: Fax:	
Name and address of division where employee works (if different from above)	Telephone: Fax:	

B. Information about the employee

Date employee was hired (Month, Day, Year)	Date employee became insured under this plan? Date employee became insured under prior plan?	What was the employee's regularly scheduled work week? _____ hours per week _____ hours per day

C. Information needed for withholding and reporting taxes

Does employee contribute post-tax dollars toward the premium? ☑ Yes ☐ No If yes, what percent is paid by the employee? 100 %

If you leave this section blank, we will assume it is 100% employer contribution and calculate FICA taxes accordingly.

D. Information about the claim

Were there any changes to the employee's job responsibilities due to the disabling condition before the employee became fully disabled?
☐ Yes ☐ No If yes, what were the changes and when were they made?

What was the employee's permanent job on his or her last day at work?	How long had the employee been in this job?

Last day employee actually worked (Month, Day, Year)	On that day, did the employee work a full day? ☐ Yes ☐ No If no, how many hours were worked?
Why did employee stop working?	Is the employee's condition work related? ☐ Yes ☐ No

Has a claim been filed with Workers' Compensation?
☐ Yes ☐ No If yes, send initial report of illness or injury and award notice.

Name, address and telephone number of your compensation carrier
City of Milwaukee (414)286-2020

Name, address and telephone number of your medical insurance carrier
United Healthcare (800)841-4901

E. Information about your pension plan (do not complete for maternity claim) (For Lincoln Financial to complete)

Do you have a pension plan?	If yes, what type?	
☑ Yes ☐ No	☑ Defined benefit ☐ 401(k) ☐ Other: (specify) ☐ Defined contribution ☐ Profit sharing	
Is the employee eligible for your pension plan? ☐ Yes ☐ No If no, why?	If eligible, does the employee participate? ☐ Yes ☐ No If no, why?	

If the employee is participating, when is he or she eligible for benefits under the plan? (Month, Day, Year)

NOTE: If any portion of this pension benefit is attributable to the employee's contribution, please provide details including the percentage of his/her contribution to the total contribution. This should include a copy of the contract.

F. 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

What is the name and title of the manager we should contact if we identify a rehabilitation or return-to-work option?
Michelle Stein (414) 286-3394

G. Information about the employee's salary

The employee (Check all that apply)
☐ is paid hourly (what is the 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, what is the weekly amount? $ _____-_____ When do benefits begin? _____ End? _____

Is this employee eligible for salary continuation?
☐ Yes ☐ No If yes, what is the weekly amount? $ _____ When do benefits begin? _____ End? _____

(Continued on next page)

Reporting the employee's basic monthly earnings

Find the definition of basic monthly earnings that matches your contract for this employee and follow the instructions given.

Definitions of Basic Monthly Earnings

a. salary only (no commissions, bonuses, etc.), complete question 1 below
b. previous year's W-2 form, complete question 5 below (attach W-2)
c. sole proprietor, complete question 8 below
d. previous year's K-1 form, complete question 6 below (attach K-1)

e. salary and commissions, complete questions 1 and 3 below
f. salary, commissions and bonuses, complete questions 1, 3 and 4 below
g. salary and deferred compensation, complete questions 1 and 2 below
h. salary, deferred compensation and commissions, complete questions 1, 2 and 3 below
i. salary, deferred compensation, commissions and bonuses, complete questions 1, 2, 3 and 4 below
j. salary and K-1 earnings, complete questions 1 and 6 below

k. W-2 with deferred compensation, complete questions 2 and 5 below
l. partnership agreement, complete question 7 below
m. teacher's contract, complete question 1 below
n. any other definition, complete question 9 below

1) On the last day employee worked, what was his or her basic monthly salary? (Divide annual salary by 12 or multiply weekly salary by 52 and divide by 12. Teachers divide annual salary by 12) (Attach copy of last pay stub) 1 _____

2) On the last day the employee worked, what was his or her monthly pre-tax contribution to your deferred compensation plan? 2 N/A

3) How much had the employee received in commissions in the 12 months (or the period of employment if less than 12 months) immediately preceding the last day worked? $ _____. Divide this number by 12, or the length of employment if less than 12 months, to find the average monthly commissions. 3 N/A

4) How much had the employee received in bonuses in the 12 months (or the period of employment if less than 12 months) immediately preceding the last day worked? $ _____. Divide this number by 12, or the length of employment if less than 12 months, to find the average monthly bonuses. 4 N/A

5) What were the employee's earnings as shown on the W-2 form of the year immediately preceding the disability? 5 N/A

6) What were the employee's earnings as shown on the K-1 form of the year immediately preceding the disability? 6 N/A

7) As of the last day the employee worked, what were the budgeted annual earnings as determined by the written partnership agreement in effect? (Do not include dividends, interest or return of capital) $ _____. 7 N/A

8) As of the last day the employee worked, what was the sole proprietor's annual net profit (1040 Schedule C gross income minus total deductions minus depreciation) averaged over the 3 years immediately preceding the disability or the period of sole proprietorship if less than 3 years? 8 N/A

9) For definitions other than those above, calculate the monthly earnings as they are defined in your contract. If earnings are based on salary as expressed on a particular document, send us a copy of the document. 9 N/A

H. Required Attachments and Signature **(DOCUMENTS PROVIDED BY DER)**

If the employee contributes to the premiums, attach a copy of the enrollment form.

If salary is based on a W-2, K-1, 1099, or a similar document, attach a copy of the document.

If you have medical information from the employee's file relating to this disability, please attach copies.

If a workers' compensation claim is filed, send initial report of injury or illness and award notice.

Name of person completing this form (If this claim is approved for disability benefits, the benefit check will be sent to the employee with a carbon copy to you.)

X _____ _____ _____
Signature Title Date

Long-Term Disability Claim Job Analysis

SKIP PAGES 4 & 5 IF YOU ATTACH COPY OF JOB DESCRIPTION.

To Be Completed By The Employee's Supervisor

This claim is for (Employee's Name)

Employee's Social Security Number	Date of Disability (Month, Day, Year)

A. General information about the employee's job

Job Title	Minimum education or training required

Does the employee perform supervisory functions?
☐ Yes ☐ No If yes, how many people are supervised? _____ Describe job duties.

Check the items below that relate to the employee's job. Use these definitions for the frequency of occurrence:

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

	Occasionally	Frequently	Continuously
Relate to others	☐	☐	☐
Written and verbal communication	☐	☐	☐
Reasoning, math and language	☐	☐	☐
Makes independent judgments	☐	☐	☐

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

☐ Unprotected heights ☐ Changes in temperature or humidity ☐ Exposure to dust, fumes and gases
☐ Being near moving machinery ☐ Driving automotive equipment ☐ Other hazards

Is the employee required to travel?
☐ Yes ☐ No If yes, complete the following information:

How does the employee travel? (Automobile, plane, train, etc.)
Where does the employee travel? What percent of the time does the employee travel?

B. Information about the physical aspects of the employee's job

Check the items below that relate to the employee's job and complete the information requested. Use these definitions for the frequency of occurrence:

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

Activity	Frequency of Occurrence				
	Occasionally	Frequently	Continuously		
☐ Standing	☐	☐	☐		
☐ Walking	☐	☐	☐		
☐ Sitting	☐	☐	☐		
☐ Balancing	☐	☐	☐		
☐ Stooping	☐	☐	☐		
☐ Kneeling	☐	☐	☐		
☐ Crouching	☐	☐	☐		
☐ Crawling	☐	☐	☐		
☐ Reaching/working overhead	☐	☐	☐		
☐ Climbing:	☐	☐	☐		
☐ Stairs Number of stairs: _____	☐	☐	☐		
☐ Ladders Height of Ladder: _____	☐	☐	☐	**Describe Activity**	**Weight**
☐ Pushing	☐	☐	☐	_____	_____ lbs.
☐ Pulling	☐	☐	☐	_____	_____ lbs.
☐ Lifting/carrying	☐	☐	☐	_____	_____ lbs.

(Continued on next page)

Can the job be performed by alternating sitting and standing?
☐ Yes ☐ No

Does the job require using the feet to operate foot controls?
☐ Yes ☐ No If yes, on what type of equipment?

How important is good vision in the job?

What are the major tasks requiring use of one or both hands?	One Hand	Both Hands
	☐	☐
	☐	☐
	☐	☐
	☐	☐

C. Information about the job as it relates to the disability

Can the job be modified to accommodate the disability either temporarily or permanently?
☐ Yes ☐ No If yes, explain

Is it possible to offer the employee assistance in doing the job (through use of technology or personal assistance for example)?
☐ Yes ☐ No If yes, explain

D. Attachments and Signature (Attach a copy of the employee's job description)

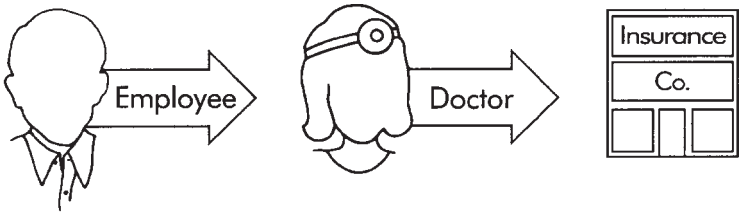
Name of person completing this form

X _____ _____ _____
Signature Title Date

Telephone Fax

The Lincoln National Life Insurance Company, PO Box 2609, Omaha, NE 68103-2609
toll free (800) 423-2765 Fax (877) 843-3950
www.LincolnFinancial.com

GROUP LONG-TERM DISABILITY CLAIM APPLICATION



EMPLOYEE - form completion information

APPLICATION FOR GROUP LTD - Instructions

A. **Complete and sign the authorization on the reverse side of this page.** This will allow our insurance carrier or their representative to secure additional information (if necessary) to make a decision on your request for benefit payments (do not detach).

B. **Complete employee claim statement in full.**

Attach • A copy of Social Security and other income entitlement awards (or forward when received)

C. **Give this authorization and attached claim application to the physician treating you** (if more than one, obtain other forms for completion from employer). Instruct your attending physician to send his statement along with yours to the insurance carrier.

D. When those forms are received by the Insurance Company, they will advise you of your eligibility for benefits or of any additional information that may be needed.

Do Not Detach

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AUTHORIZATION FOR RELEASE OF INFORMATION

1. **I (the undersigned) authorize** any physician, medical professional, pharmacist or other provider of health care services, hospital, clinic, other medical or medically related facility; insurance or reinsurance company; government agency; department of labor; acquaintance; group policyholder; employer; or policy or benefit plan administrator to release information from the records of:

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

   Date of Birth: _____ Social Security Number: _____

2. Information to be released:
   - data or records regarding my medical history, treatment, prescriptions, consultations [including medical and psychological reports, records, charts, notes (excluding psychotherapy notes), x-rays, films or correspondence, and any medical condition I may now have or have had];
   - any information regarding insurance coverage; and
   - any information, data or records regarding my activities (including records relating to my Social Security, Workers' Compensation, Retirement Income, financial, earnings and employment history).

3. Information to be released to: The Lincoln National Life Insurance Company
   PO Box 2609
   Omaha, NE 68103-2609

4. I understand the information obtained by use of this Authorization will be used by The Lincoln National Life Insurance Company ("Company") to evaluate my claim for disability benefits. The Company will only release such information:
   - to its reinsurer, or other persons or organizations performing business or legal services in connection with my claim(s); or
   - to a vendor, approved by the company, which specializes in the application for Social Security Disability Benefits
   - to vendors/consultants providing the claimant with wellness, disability or leave related services as part of an employer sponsored benefit plan
   - to the employer for self-insured disability plans; or
   - as otherwise may be required by law or as I may further authorize.

   I further understand that refusal to sign this Authorization may result in the denial of benefits.

5. I understand the information used or disclosed may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. For Colorado claims, the disclosed information may <u>not</u> be redisclosed or reused by the recipient under Colorado law.

6. I understand that I may revoke this Authorization in writing at any time, except to the extent:
   1. the Company has taken action in reliance on this Authorization; or
   2. the Company is using this Authorization in connection with a contestable claim.

   If written revocation is not received, this Authorization will be considered valid for a period of time not to exceed 24 months from the date of my signature below. To initiate revocation of this Authorization, direct all correspondence to the Company at the above address.

7. A photocopy of this Authorization is to be considered as valid as the original.

8. I understand I am entitled to receive a copy of this Authorization.

SIGNATURE: _____ **DATE:** _____
Claimant/legal representative (Nearest relative, legal guardian, or appointed representative to sign only if claimant/patient is a minor, legally incompetent, or deceased.) Power of attorney or guardianship must be attached.

PRINT NAME: _____

Relationship to Claimant/Patient of personal/legal representative signing for Claimant/Patient: _____

ADDRESS: _____ PHONE NO: _____
(Street)

_____
(City) (State) (Zip Code)

FRAUD NOTICES. For your protection, certain states require that the following notices appear on this form.

Alaska. A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under state law.

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, Rhode Island and 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 to appear on this form: Any person who knowingly 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.

Delaware. 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. 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 application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Idaho. Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement or claim containing any false, incomplete or misleading information is guilty of a felony.

Indiana. A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

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. 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.

Maryland. Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or 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.

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 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.

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 subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

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, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Oregon. Any person who knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or, (2) conceals for the purpose of misleading, information concerning any material fact, may have committed a fraudulent insurance act.

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 are 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.

Tennessee and 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.

Texas. Any person who knowingly 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.

FOR ALL OTHER STATES EXCLUDING CONNECTICUT, KANSAS, AND VIRGINIA. A person may be committing insurance fraud, if he or she submits an application or claim containing a false or deceptive statement with intent to defraud (or knowing that he or she is helping to defraud) an insurance company.

Long-Term Disability Claim Employee's Statement

To Be Completed By The Employee

A. Information about you

Last Name	First	Middle Initial

Address	City	State/Province	Zip

Telephone	Social Security Number

Date of Birth (Month, Day, Year)	Height	Weight	☐ Rt Handed ☐ Lt. Handed	☐ Male ☐ Female	☐ Single ☐ Married	☐ Widowed ☐ Divorced

Your Employer (include division if applicable)

Occupation

B. Information about your family (required to determine your eligibility for Social Security benefits)

Spouse's Name (Last, First)

Spouse's Social Security Number	Date of Birth (Month, Day, Year)	Is your spouse employed? ☐ Yes ☐ No

Children under age 25: Name (Last, First)	Date of Birth (Month, Day, Year)

C. Information about the condition causing your disability

1. For **pregnancy** or **illness**, answer the following questions:

What were your first symptoms?

When did you first notice them?	Date you were first treated by a physician (Month, Day, Year)

2. For an **injury**, answer the following questions:

Where and how did the injury occur?

Date the injury occurred (Month, Day, Year)	Date you were first treated by a physician (Month, Day, Year)

3. For **illness** or **injury**, 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, explain

Is your condition related to your occupation?
☐ Yes ☐ No If yes, explain

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

Do you require another person's active, hands-on help to safely perform activities of daily living?
☐ Yes ☐ No If yes, please explain what kind of help you receive and who provides it:

D. Information about the disability

Last day you worked before the disability (Month, Day, Year)	Did you work a full day? ☐ Yes ☐ No If no, explain	Date you were first unable to work? (Month, Day, Year)

Have you returned to work? ☐ Yes Part time (date) _____ Full time (date) _____ ☐ No	If you have not returned to work, do you expect to? ☐ Yes Part time (date) _____ Full time (date) _____ ☐ No

Are you currently self-employed or working for another employer?
☐ Yes ☐ No If so, give details.

(Continued on next page)

E. Information about physicians and hospitals

First medical attention for the current disability was given by (complete below):

Doctor's Name	Telephone: Fax:	Specialty
Address (Street, City, State, Zip)		Dates Seen To

List all other physicians and hospitals you have seen for this condition:

Doctor's Name	Telephone: Fax:	Specialty
Address (Street, City, State, Zip)		Dates Seen To
Doctor's Name	Telephone: Fax:	Specialty
Address (Street, City, State, Zip)		Dates Seen To
Doctor's Name	Telephone: Fax:	Specialty
Address (Street, City, State, Zip)		Dates Seen To
Hospital	Telephone: Fax:	Specialty
Address (Street, City, State, Zip)		Dates of Confinement To

Have you ever had the same or a similar condition in the past?
☐ Yes ☐ No If yes, complete the following concerning your past treatment:

Doctor's Name	Telephone: Fax:	Specialty
Address (Street, City, State, Zip)		Dates Seen To
Hospital	Telephone: Fax:	Specialty
Address (Street, City, State, Zip)		Dates of Confinement To

F. Information about other disability income

(Check the other income benefits you are receiving or are eligible to receive as a result of your disability and complete the information requested.)

Source of Income	Amount	(wk., mon.)	Date claim was filed	Date payments began	Date payments ended
Social Security Retirement	$ _____	/ _____	_____	_____	_____
Social Security Disability/Yourself	$ _____	/ _____	_____	_____	_____
Social Security Disability/Dependents	$ _____	/ _____	_____	_____	_____
Canadian Pension Plan	$ _____	/ _____	_____	_____	_____
Workers' Compensation	$ _____	/ _____	_____	_____	_____
State Disability	$ _____	/ _____	_____	_____	_____
Pension/Retirement	$ _____	/ _____	_____	_____	_____
Pension/Disability	$ _____	/ _____	_____	_____	_____
Short Term Disability	$ _____	/ _____	_____	_____	_____
Unemployment	$ _____	/ _____	_____	_____	_____
No-Fault Insurance	$ _____	/ _____	_____	_____	_____
Railroad Retirement	$ _____	/ _____	_____	_____	_____
Other (include individual or group benefits):	$ _____	/ _____	_____	_____	_____

G. Information about income tax withholding

If your request for benefits is approved, should The Lincoln National Life Insurance Company withhold income taxes from your benefit checks?
☐ Yes ☐ No If yes, how much should be withheld from each check. Federal taxes (minimum is $88.00 per month) $ _____ .00

H. Signature (Required for all claims)

Under what other The Lincoln National Life Insurance policies are you currently covered?

The above Statements are true and complete to the best of my knowledge and belief. I have read and understand the attached Fraud Warning statements.

X _____ _____

Signature of Employee Date

Long-Term Disability Claim Physician's Statement

This form should be completed by the physician who was treating the claimant when he or she last worked.

To Be Completed By The Attending Physician

A. General information

This claim is for (Patient's Name)

Patient's Social Security Number	Height	Weight	Blood Pressure	Date of Birth (Month, Day, Year)

Primary Diagnosis including ICD 9 or DSM code

B. Complete this section for normal pregnancy, then go to section E.

What was the date of the last menstrual period?	What is the expected date of delivery?	
What is the expected length of postpartum recovery?	What was the first date of treatment?	What was the last date of treatment?

C. Complete this section for all conditions except normal pregnancy.

Symptoms

Objective Findings

Are there secondary conditions contributing to the disability?
☐ Yes ☐ No If yes, what are they? (Please include ICD 9 or DSM code.)

If this is a cardiac condition, what is the functional capacity? (American Heart Association)
☐ Class 1 - No limitation
☐ Class 2 - Slight limitation
☐ Class 3 - Marked limitation
☐ Class 4 - Complete limitation

When did symptoms first appear?	Date of the patient's first visit (Month, Day, Year)	Date you believe the patient was first unable to work (Month, Day, Year)

Date of the patient's last visit (Month, Day, Year)	How often do you see the patient?

Is the patient's condition work related?
☐ Yes ☐ No If yes, explain:

Has the patient undergone surgery?
☐ Yes ☐ No If yes, give date, procedure and result.

If no, do you expect surgery to be performed in the future?
☐ Yes ☐ No If yes, give date and type of surgery.

What medication is the patient currently taking?

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, complete the following:

Name of Hospital

Address	Dates of Confinement through

D. Information about the patient's inability to work

Briefly describe restrictions and limitations.

Restrictions (What the patient SHOULD NOT do)

Limitations (What the patient CANNOT do)

What is your prognosis for recovery?

Has patient achieved maximum medical improvement?
☐ Yes ☐ No If no, complete the following:

How soon do you expect fundamental changes in the patient's medical condition?
☐ 1 - 2 months ☐ 5 -6 months
☐ 3 - 4 months ☐ more than 6 months

Give details concerning expected improvement or deterioration:

In an eight hour workday, claimant can: (Circle full hourly capacity for each 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	Comments
Lifting/Carrying	☐	☐	_____
Use of hands in repetitive actions	☐	☐	_____
Use of feet in repetitive movements	☐	☐	_____
Bending	☐	☐	_____
Squatting	☐	☐	_____
Crawling	☐	☐	_____
Climbing	☐	☐	_____
Reaching above shoulder level	☐	☐	_____
Other (please specify)	☐	☐	_____

When do you expect claimant to return to prior level of functioning?

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

Has your patient had loss of cognitive functioning? "Cognitive impairment" means a permanent deterioration or loss of cognitive or intellectual capacity and requires another person's hands-on help or verbal cues to prevent harm to self or others due to impairment
☐ Yes ☐ No If yes, please explain and provide supporting medical documentation and testing:

Based on your observations of this patient, medical history and condition, has your patient lost the ability to safely and completely perform Activities of Daily Living (ADLs) without another person's active hands-on help with all or most of the activity:

ADL Date on which assistance was first required and received

☐ Bathing_____ (washing self in tub, shower or by sponge bath, with or w/o equipment)
☐ Dressing_____ (putting on, taking off garmets, braces or any artificial limbs normally worn)
☐ Toileting_____ (getting to, from, on and off toilet; and performing related personal hygiene)
☐ Transferring _____ (moving in & out of bed, chair or any wheelchair, with or w/o equipment)
☐ Continence_____ (voluntarily maintaining control of bladder and bowel function)
☐ Eating_____ (getting nourishment into one's body by any means (table/tray or special equipment)

If the claimant has lost the ability to perform ADLs listed above, please provide any supporting medical documentation and testing.

If the patient has lost the ability to perform any ADLs listed above, do you expect the limitations to be permanent?
☐ Yes ☐ No If "no", please explain when improvement may be expected:

E. Required Attachments and Signature

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

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

Your Name | Degree

Specialty | Telephone:
Fax:

Address

X _____ _____

Signature of Attending Physician (no stamp) | Date