

GROUP LIFE - Waiver of Premium / Permanent Total Disability (PTD) / Disability Extension Claim Form



INSTRUCTION PAGE

Claim form to waive premium on Group Life Insurance for covered employees who have become disabled and are unable to work.

Why apply for Group Life Waiver of Premium?

If employees become disabled as defined by their Group Life plan, the Waiver of Premium benefit, featured on many of The Hartford's Group Life Insurance policies, offers a safeguard against losing valuable Group Life coverage. For employees who apply and are approved, no Group Life premiums are due after the Waiver of Premium waiting period has been satisfied, and coverage continues in accordance with the policy provisions. ****Reminder** Group Life Premiums are due and payable during the Waiver of Premium waiting period unless the employee has already converted coverage to an individual policy.**

EMPLOYER'S RESPONSIBILITY - SECTION 1

1. Detach and complete the Employer Section. Sign and date the Employer's Section. Without this information, the claim process cannot continue.
2. If any portion of the Group Life coverage was elected, please attach a copy of the enrollment history for all benefit elections elections.
3. Attach a copy of the most recent Beneficiary Designation Form.
4. Give the remaining sections of the form, including this instruction sheet, to your employee. Ask him or her to complete the Employee Sections and return the claim form to The Hartford. (Your employee should detach the *Attending Physician's Statement of Disability*, Attending Physician's Statement, pages 1 through 4, and forward to his/her physician for completion.)
5. **SUBMIT THE EMPLOYER'S STATEMENT & ATTACHMENTS DIRECTLY TO THE HARTFORD BEFORE THE 12-MONTH DEADLINE.**

EMPLOYEE'S RESPONSIBILITY - SECTION 2

1. Complete Employee Section - pages 1 and 2. Sign and date the claim form on Employee Section - page 3.
2. Read and complete Employee Section 2 - page 4. Sign and date the authorization at the bottom of the Employee Section 2 - page 4.
3. On the *Attending Physician's Statement of Disability*, complete and sign the Employee information and authorization at the top of the Attending Physician's Statement - page 1. Remove the *Attending Physician's Statement of Disability Section* (Attending Physician's Statement) - pages 1 through 4 from this claim form and give it to the physician certifying your disability. Ask your physician to complete the form and return it within 10 days to The Hartford. Be aware that you are responsible for any fees charged by your physician for completion of this form.
4. **SUBMIT THIS APPLICATION BEFORE THE 12-MONTH DEADLINE*** To qualify for benefits, submit the completed Employee Sections and all attachments, by the deadline* specified in your Group Life plan. Make a copy to keep with your records. The *Attending Physician's Statement* should be sent separately by the physician before the same deadline. The Employer section should be sent separately before the same deadline.
5. Please follow up to make sure that this claim form, all attachments, and the *Attending Physician's Statement of Disability* are received by The Hartford within the deadline* specified in your Group Life plan.

SEND THE CLAIM FORM TO:

THE HARTFORD
Group Life Claims
P. O. Box 946790
Maitland, FL 32794-6790

OR FAX TO:

Group Life Claims
(866)-954-2621

For questions about how to complete this form, call Hartford Life Toll-free at **1-888-563-1124**

***The deadline for submission is usually 12 months from the employee's last day of work; check your plan to be sure.** Coverages underwritten by Hartford Life Insurance Company, Hartford Life Insurance Company or Hartford Life and Accident Insurance Company.

GROUP LIFE - Waiver of Premium / Permanent Total Disability (PTD) / Disability Extension Claim Form



EMPLOYER SECTION 1

This is a time-sensitive document

***Submission deadline is usually 12 months from the last day of work; check your plan.**

A. INFORMATION ABOUT YOUR COMPANY

Company Name Board of Supervisors of Louisiana State University and Agricultural and Mechanical College			
Address (Street, City, State, Zip Code)			
Name and address of division where employee works, if different from above:			
Group Policy Number 395208	Telephone Number ()	Fax Number ()	E-Mail address

B. INFORMATION ABOUT YOUR EMPLOYEE

Employee's Name		Social Security Number	Date of Birth
Address (Street, City, State, Zip Code)		Telephone Number ()	
Date hired: <input type="checkbox"/> Full time <input type="checkbox"/> Part time	Date Group Life Insurance became effective:		Last day worked:
Campus Name & Code		<input type="checkbox"/> Exempt	<input type="checkbox"/> Non-exempt <input type="checkbox"/> Salaried <input type="checkbox"/> Hourly
Group Life: Insurance coverage amount: Basic Life \$ _____		Supplemental Life \$ _____ (Attach enrollment forms & beneficiary form.)	
Permanent Total Disability Benefits:			
Amount of Basic Life Insurance \$ _____		Amount of Supplemental Life Insurance \$ _____	
Amount of Permanent Total Disability requested \$ _____		Number of hours scheduled to work weekly _____	
Rate of Annual Basic Earnings on date last worked: \$ _____ per <input type="checkbox"/> Hour <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year (Attach W-2, if applicable)			
Do earnings include commissions, bonuses or overtime? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," please specify:			
Are employee's eligible dependents covered by Waiver of Premium benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," please provide amounts of Group Life coverage and enrollment history:			
Spouse's Name: _____		Date of Birth: _____	Coverage Amount: _____
Child's Name: _____		Date of Birth: _____	Coverage Amount: _____
Child's Name: _____		Date of Birth: _____	Coverage Amount: _____
Has employment been terminated/retired? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," date: _____			
Was an application for conversion offered? <input type="checkbox"/> Yes <input type="checkbox"/> No			

C. INFORMATION ABOUT THE DISABILITY

Before the employee became totally disabled, were any changes made to the employee's job responsibilities because of the disabling condition? <input type="checkbox"/> Yes <input type="checkbox"/> No. If "Yes," what were the changes and when were they made? _____	
What was the employee's permanent job or occupation title on his or her last day at work? _____	
How long had the employee been in this job? _____	Full time? <input type="checkbox"/> Yes <input type="checkbox"/> No
Date employee is expected to, or did return to work: _____	Why did employee stop working? _____
Is the cause of employee's condition work related? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is your employee receiving income from other sources? e.g.: <input type="checkbox"/> Short Term Disability <input type="checkbox"/> Long Term Disability <input type="checkbox"/> Workers' Compensation <input type="checkbox"/> Social Security (If applicable, provide name and address of insurance carrier:)	

D. REQUIRED ATTACHMENTS AND SIGNATURE

For Voluntary Group Life Insurance coverage, attach a copy of the enrollment form history, and/or copies of the Electronic Benefits (screen prints). I hereby certify that the information provided in the Employer's Section is true and complete to the records of the Employer, I agree that this information is subject to audit by Hartford Life Insurance Company or Hartford Life and Accident Insurance Company or Hartford Life Group Insurance Company and/or its representatives.

Name (Please print or type) _____		Title _____	
Signature of Employer Representative _____		()	
Date _____		Telephone Number _____	

GROUP LIFE - Waiver of Premium / Permanent Total Disability (PTD) / Disability Extension Claim Form



EMPLOYEE SECTION 2

This is a time-sensitive document

*Submission deadline is usually 12 months from the last day of work; check your plan.

Group Policy Number: 395208

Employer Name: Board of Supervisors of Louisiana State University and Agricultural and Mechanical College

Be sure to answer all questions - missing information may delay your claim.

A. INFORMATION ABOUT YOU

Name: _____

Address: _____

Telephone Number: () _____

Male Female

E-Mail address: _____

At the time your TOTAL disability began, were you working more than one job (including self-employment)? Yes No
If "Yes," provide the name, address and phone number of other employers and indicate the dates when you worked (or were self-employed).

Please indicate your educational history: (Check or Circle last year completed.)

Education through High School

College

Masters

Ph.D.

1 2 3 4

1 2 3 4

Are you now attending school? Yes No

Trade or technical school: (Describe course of study.)

Describe your last four jobs. (Begin with your most recent job.)

Company	Job Title	Duties	Years
(a) _____	_____	_____	_____
(b) _____	_____	_____	_____
(c) _____	_____	_____	_____
(d) _____	_____	_____	_____

Are you receiving any income from other sources?

	Amount	Name	Address	Phone
Short Term / Long Term Disability	\$ _____	_____	_____	() _____
Workers' Compensation	\$ _____	_____	_____	() _____
Individual Disability	\$ _____	_____	_____	() _____
Self-employment or Part-time work	\$ _____	_____	_____	() _____

B. INFORMATION ABOUT THE CONDITION CAUSING YOUR DISABILITY

Describe your medical condition: _____

Why did you stop working? _____

If caused by an illness, have you had this illness before? Yes No If "Yes," when? _____

If caused by an injury, when, where and how did the injury occur? _____

Date you were first treated by a Medical Provider for the disabling illness or injury: _____

Name of Medical Provider: _____

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: _____

What aspect of your condition made you unable to work? _____

Is the cause of your condition related to your job? Yes No If "Yes," explain: _____

What important duties of your job are you unable to perform? _____

Are you now engaged in the duties of any occupation or endeavor for wages, profit, compensation or volunteerism? Yes No

C. INFORMATION ABOUT YOUR DISABILITY

Last day you physically reported to work: _____ Since that date, have you done any work? Yes No
If "Yes," please indicate dates worked, name and address of employer and amount earned.

Have you returned to work in any capacity? Yes No If you have not returned to work, do you expect to? Yes No
If "Yes," part-time (date) _____ full-time (date) _____

D. INFORMATION ABOUT YOUR PHYSICIANS

List all physicians you have seen for this condition (attach a separate sheet if needed)

Doctor's Name Specialty Dates seen

Address () ()

City/State/Zip Code Telephone Number FAX Number

Doctor's Name Specialty Dates seen

Address () ()

City, State, Zip Code Telephone Number FAX Number

Doctor's Name Specialty Dates seen

Address () ()

City, State, Zip Code Telephone Number FAX Number

E. EMPLOYEE'S SIGNATURE

Please read the statement that applies to your residence and sign the bottom of the page.

For residents of all states EXCEPT California, Florida, New Jersey, Colorado, Pennsylvania, Arkansas, New Mexico, Louisiana, New York, Virginia, Puerto Rico and District of Columbia: A person commits a fraudulent insurance act if that person knowingly, and with intent to defraud any insurance company or other person, either: (a) files an application for insurance or statement of claim containing any materially false information, or (b) conceals information concerning any material fact in order to obtain an insurance policy or a benefit under an insurance policy. **A fraudulent insurance act is a crime.** (In Oregon, a fraudulent insurance act may be a crime.) The Hartford shall pursue prosecution of any fraudulent insurance act to the fullest extent of the law.

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

For residents of New Jersey, Arkansas, and New Mexico: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

For residents of 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 a person to criminal and civil penalties.

For residents of Colorado: It is unlawful to knowingly provide false, incomplete, or misleading 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 its agent who knowingly provides false, incomplete, or misleading information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to an insurance settlement or award shall be reported to the Colorado Division of Insurance.

FOR RESIDENTS OF 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."

For residents of Louisiana: 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.

For residents of 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.

For residents of Puerto Rico: Any person who knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

For residents of Virginia: 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.

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

The statements contained in this application for Group Life Waiver of Premium / Permanent Total Disability / Disability Extension Application are true and complete to the best of my knowledge and belief.

X _____ **X** _____
Signature of the Employee Date

**RETURN COMPLETED EMPLOYEE STATEMENT TO: THE HARTFORD or Fax to: Group Life Claims
Group Life Claims
P. O. Box 946790
Maitland, FL 32794-6790 (866)-954-2621**

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION



To: Any health care provider, employer, benefit plan, insurer, financial institution, consumer reporting agency, educational institution, or Federal, State, or Local Government Agency, including the Social Security Administration and Veterans Administration. I authorize you to disclose to The Hartford¹ a complete copy of any and all of the following personal or privileged information, records or documents relative to:

Insured's Name (*Please print*) Date of Birth Last 5 Digits of Social Security Number

Any and all medical information or records, including x-ray films, medical histories, physical, mental or diagnostic examinations, and treatment notes, and including information regarding HIV/AIDS, communicable diseases, alcohol or drug abuse, and mental health, as such information may be related to my claim for benefits; work information and history, including job duties, earnings and personnel records, and client lists; information on any insurance coverage and claims filed, including all records and information related to such coverage and claims; credit information, including credit reports and credit applications; other financial information, including pension benefits, bank records; business transactions billing, invoices, and payment records; academic transcripts; and information concerning Social Security benefits, including, monthly benefit amounts, monthly payment amounts, entitlement dates, and information from my Master Beneficiary Record. The information obtained by use of this Authorization will be used for the purpose of evaluating and administering my claim for benefits under my employer's benefit plan. Such information shall be referred to herein collectively as "My Information." I understand I have the right to revoke this Authorization for future disclosures, except to the extent action has been taken in reliance upon this Authorization. I must revoke this Authorization in writing directly to The Hartford.

I ALSO UNDERSTAND that once My Information has been disclosed to The Hartford, as permitted under this Authorization, it may be re-disclosed by The Hartford as permitted by law or my further authorization. I authorize The Hartford to use or disclose My Information (i) to my employer for; a) functions related to accommodating my disability; b) responding to claims related to accommodation or adverse or discriminatory treatment related to my claim; c) responding to any litigation or agency charge document production request or lawful subpoena; d) federal or state Family & Medical Leave Act administration; e) matters relating to its workers' compensation arrangements; or f) fulfilling fiduciary obligations under my benefit plan; (ii) to the administrator or other service providers of my employer's benefit plan or other benefit plans of my employer for plan-related functions; (iii) to any claim system used for claims processing or insurance broker to carry out functions related to my benefit plan or claim; (iv) to any health care professional who has treated or evaluated me or who may do so; (v) to other persons or entities performing business or legal services related my claim; vi) to my employer's workers' compensation insurance carrier or administrator; (vii) as may be lawfully required; or (viii) as may be necessary to prevent or detect perpetration of a fraud.

I understand that information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient. I understand that I have the right to revoke this Authorization for future disclosures The Hartford may make unless The Hartford has taken action in reliance upon this Authorization. I must revoke this Authorization in writing directly to The Hartford. I understand that my medical treatment or payment for medical benefits cannot be conditioned on my allowing The Hartford to re-disclose My Information. The authorizations set forth herein expire two years from the date listed below, or upon my revocation, if earlier, but will not exceed the term of my coverage under the policy or benefit plan, except as may be necessary to prevent or detect perpetration of a fraud. I understand that I am entitled to receive a copy of this Authorization upon request. A photocopy or facsimile of this Authorization shall be as valid as the original. If there is a conflict between a prior request for restriction on the disclosure of My Information and this Authorization, this Authorization will control.

Signature of Insured or Guardian Relationship to Insured (*if signed by Guardian*) Date

¹ The Hartford® is The Hartford Financial Services Group, Inc., and its subsidiaries, including issuing companies Hartford Fire Insurance Company, Hartford Life Insurance Company, Hartford Life and Accident Insurance Company, and its administrative services company Hartford-Comprehensive Employee Benefit Service Company, and any of their parents, affiliates, subsidiaries and/or third-party contractors. Also as used herein, The Hartford provides insurance or claim administration services to my employer's employee welfare benefit plan(s).

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ATTENDING PHYSICIAN'S STATEMENT

This is a time-sensitive document

Submission deadline is usually 12 months from the last day of work; check your plan.

The employee is responsible for any physician fees for the completion of this form.

This section to be completed and signed by the Employee

Name of Patient _____		
Address (Street) _____		
(City/State/Zip Code) _____		
()		
Telephone Number _____	Date of Birth _____	Social Security Number _____
Board of Supervisors of Louisiana State University and Agricultural and Mechanical College		
Employer and Division (if applicable) _____		
I hereby authorize my physician to release any information concerning my medical condition(s) for the purpose of claim processing.		
Patient's Signature _____		Date _____

Physician's Instructions **Please respond within 10 Days**

A delay in returning a completed *Attending Physician's Statement* could result in your patient's being disqualified from receiving valuable Life Insurance benefits.

Please complete the remainder of this form for your patient. Sign and date the last page.

SEND THE COMPLETED FORM TO:

THE HARTFORD
Group Life Claims
P. O. Box 946790
Maitland, FL 32794-6790

OR FAX TO:

Group Life Claims
(866)-954-2621

If you have questions, call The Hartford Toll-free at 1-888-563-1124

This section to be completed by the Attending Physician

A. PATIENT INFORMATION

Height _____ Weight _____
Patient's condition is the result of: <input type="checkbox"/> Illness <input type="checkbox"/> Injury <input type="checkbox"/> Pregnancy <input type="checkbox"/> Other
Is condition due to illness or an injury that is work related? <input type="checkbox"/> Yes <input type="checkbox"/> No

B. DIAGNOSIS

Primary diagnosis _____	ICD-9 Code _____
Secondary diagnosis(es) _____	ICD-9 Code _____
Concurrent/Co-morbid conditions(s) _____	ICD-9 Code _____
Subjective symptoms: _____	
Objective findings: _____	

C. TREATMENTS

Date you first treated this patient _____ Date you first treated this patient for this condition _____

Date Patient was first advised to stop working due to Illness/Injury _____

Date of onset of this condition _____ Date of most recent treatment _____

How often has patient been seen or treated? _____ Date of next office visit. _____

Has patient been referred to any other physician? Yes No
 If "Yes":
 Physician's name _____ Physician's Telephone Number (____) _____
 Physician's address _____
 Specialty _____ Date of office visit _____

Nature of treatment for this condition _____

Has surgery been performed? Yes No If "Yes", Date _____

Procedure _____ CPT Code: _____

Was patient hospitalized for this condition? Yes No If "Yes,"
 Name and address of hospital(s) _____

Date(s) admitted _____ Date(s) discharged _____

Progress (please check one) Recovered Improved Unchanged Retrogressed

D. PHYSICAL IMPAIRMENTS

1. Indicate the extent to which the patient's ability to perform any of the following activities is limited by his or her disorder.
 In an 8-hour workday, the patient can (Circle or check number of hours):

Sit for 0 1 2 3 4 5 6 7 8 hours at a time Stand for 0 1 2 3 4 5 6 7 8 hours at a time
 Walk for 0 1 2 3 4 5 6 7 8 hours at a time Drive for 0 1 2 3 4 5 6 7 8 hours at a time

2. Check the maximum limit and frequency that the patient can lift/carry:

	Never	Occasionally	Frequently	Constantly
1-10 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11-20 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21-50 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
51-100 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
over 100 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

D. PHYSICAL IMPAIRMENTS (cont'd)

3. Check the maximum limit and frequency that the patient can lift/carry:

	Never	Occasionally	Frequently	Constantly
Climbing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Balancing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stooping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kneeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crouching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crawling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching				
Above shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Below waist level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
At waist level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Handling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fingering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. Indicate the patient's capacity for repetitive use of feet and hands.

Right hand Yes No Left hand Yes No Both hands Yes No
 Right foot Yes No Left foot Yes No Both feet Yes No

4a. Dominant hand (check one) Right Left

5. If any other activities are limited, please specify the activities and the limitations

6. If the patient's vision is impaired, please describe the extent of the impairment _____

Date vision test was performed _____ Visual Acuity:

	R	L
Corrected	<input type="text"/>	<input type="text"/>
Non-Corrected	<input type="text"/>	<input type="text"/>

7. From the following classifications of work strength requirements, please describe the exact degree of work you feel this patient is capable of performing*:

- Sedentary Work:** Lifting 10 lbs. maximum and occasionally lifting and/or carrying articles such as docket, ledgers and small tools. A job is considered sedentary if it involves primarily sitting, and requires only occasional walking and standing.
- Light Work:** Lifting 20 lbs. with frequent lifting and/or carrying of objects weighing up to 10 lbs. A job is considered Light Work if it involves sitting most of the time with a degree of pushing and pulling or use of arm and/or arm controls; or when it requires walking or standing to a significant degree.
- Medium Work:** Lifting 50 lbs. maximum with frequent lifting and/or carrying of objects weighing up to 25 lbs.
- Heavy Work:** Lifting 100 lbs. maximum with frequent lifting and/or carrying of objects weighing up to 50 lbs.
- Very Heavy Work:** Lifting more than 100 lbs. with frequent lifting and/or carrying of objects weighing 50 lbs or more.

*Five degrees of work are taken from the Dictionary of Occupational Titles, Volume II, pages 654-655, published by the U.S. Dept of Labor (3rd ed. 1965)

8. Are there environmental workplace restrictions for this patient as a result of the patient's impairment? Yes No
 "If Yes," describe:

9. CARDIAC (complete if disability is due to heart condition) Class 1 (No limitation) Class 2 (Slight limitation)
 Class 3 (Marked limitation) Class 4 (Complete limitations)

Remarks: _____

E. PSYCHIATRIC IMPAIRMENTS (if applicable)

What problems with stress or interpersonal relations has the patient had on the job? Indicate the degree to which the patient is able to perform the duties of their occupation.

- Class 1 - No Limitations:** Patient is able to function under stress and engage in interpersonal relations.
- Class 2 - Slight Limitations:** Patient is able to function in most stress situations and engage in only limited interpersonal relations.
- Class 3 - Moderate Limitations:** Patient is able to engage in stress situations or engage in only limited interpersonal relations.
- Class 4 - Marked Limitations:** Patient is unable to engage in stress situations or engage in interpersonal relations.
- Class 5 - Severe Limitations:** Patient has significant loss of psychological, physiological, personal and social adjustment.

Do you believe the patient is competent to endorse checks and manage the proceeds appropriately? Yes No

Remarks: _____

GAF Score: _____ Date: _____

What are the stressors? _____

Job Related? Yes No

F. OUTLOOK

Has the patient reached maximum medical improvement Yes No

Date patient can return to work at his/her regular job: _____
Month Day Year

Specify: Without restrictions
 With restrictions, as noted

Date patient can return to work at a different job in a lighter duty capacity _____
Month Day Year

How long do you expect the restrictions and limitations from any work to continue? _____

G. PHYSICIAN INFORMATION

Physician's Name: _____ Social Security Number or EIN _____

Address: (Street, City, State, Zip Code) _____

Specialty _____ Licence Number _____ Telephone Number () _____ Fax Number () _____

Physician's Signature _____ Date _____

PLEASE ATTACH OFFICE NOTES, CONSULTATION REPORTS, OR ANY DIAGNOSTIC TESTS THAT ILLUSTRATE CURRENT LIMITATIONS AND RESTRICTIONS.