

ATTENDING PHYSICIAN'S STATEMENT

AS REQUIRED BY LAW, ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR A STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERE TO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND MAY ALSO BE SUBJECT TO CIVIL PENALTIES FOR EACH SUCH VIOLATION.

The patient is responsible for the completion of this form without expense to the Company.

Name of Patient _____ Date of birth _____
Mo. Day Year
Height _____ Weight _____

1. HISTORY

- (a) Has patient ever had same or similar condition? Yes No If "Yes", state when and describe:
 (b) Is condition due to injury or sickness arising out of patient's employment? Yes No Unknown
 (c) Names and addresses of other treating physicians

2. DIAGNOSIS

- (a) Diagnosis (including any complications)
 (b) Subjective symptoms

 (c) Objective findings (including current X-rays, EKG's, Laboratory Data and any clinical findings)

3. ENTER DATES FOR THE FOLLOWING

- | | MONTH | DAY | YEAR |
|--|------------------------------------|-------|-------|
| (a) Date symptoms first appeared or accident happened | _____ | _____ | _____ |
| (b) Date of first visit | _____ | _____ | _____ |
| (c) Date patient was first unable to work due to disability | _____ | _____ | _____ |
| (d) Date of most recent treatment for this disability | _____ | _____ | _____ |
| (e) Frequency of Treatment <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other (Specify) _____ | | | |
| (f) Date patient will be able to perform usual work | | | |
| | <input type="checkbox"/> Full Time | _____ | _____ |
| | <input type="checkbox"/> Part Time | _____ | _____ |
| (g) For Pregnancy Disability Only: Expected Date of Delivery | _____ | _____ | _____ |
- Are there any present complications or anticipated difficulties with Pregnancy, Delivery and/or Post Partum? Yes No
 If "Yes", please explain _____

4. NATURE OF TREATMENT (including surgery and medications prescribed, if any)

5. PROGRESS

- (a) Has patient Recovered? Improved? Unchanged? Retrogressed?
 (b) Is patient Ambulatory? House confined? Bed confined Hospital confined?
 (c) Has patient been hospital confined? Yes No If "Yes", give Name and Address of Hospital

Confined from _____ through _____

NAME (ATTENDING PHYSICIAN) PLEASE PRINT _____ DEGREES / SPECIALTY _____ TELEPHONE _____ FAX _____

STREET ADDRESS _____ CITY OR TOWN _____ STATE OR PROVINCE _____ ZIP CODE OR POSTAL CODE _____

SIGNATURE

SEND COMPLETED FORMS TO:

Disability Insurance Specialists
 Fax # (860) 769-6986

DATE

PO Box 29, Bloomfield, CT06002
 Phone # 1-800-722-9680

