For your protection, the following disclosures are required by state law and are based on the state where you live:

If you live in the state of Alaska, the following statement applies to you:
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.

If you live in the state of Alabama, the following statement applies to you:
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

If you live in the states of Arkansas, Louisiana, Massachusetts, Minnesota, New Mexico, Rhode Island, Texas or West Virginia, the following statement applies to you:
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.

If you live in the state of Arizona, the following statement applies to you:
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.

If you live in the state of California, the following statement applies to you:
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.

If you live in the state of Colorado, the following statement applies to you:
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.

If you live in the District of Columbia, the following statement applies to you:
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.

If you live in the states of Delaware, Idaho or Indiana, the following statement applies to you:
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.

If you live in the state of Florida, the following statement applies to you:
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.

To avoid unnecessary delays, be sure all parts of the Claim Statement are completed according to the instructions, and DO NOT SEPARATE the pages.

Sun Life Financial is the brand name for products underwritten or provided by Union Security Insurance Company.

© 2017 Sun Life Assurance Company of Canada, Wellesley Hills, MA 02481. All rights reserved. Sun Life Financial and the globe symbol are registered trademarks of Sun Life Assurance Company of Canada. Visit us at www.sunlife.com/us.
If you live in the state of Kansas, the following statement applies to you:
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 may be guilty of insurance fraud as determined by a court of law.

If you live in the state of Kentucky, the following statement applies to you:
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.

If you live in the state of Maryland, the following statement applies to you:
Any person who knowingly OR willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly OR willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

If you live in the state of Maine, the following statement applies to you:
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.

If you live in the state of New Hampshire, the following statement applies to you:
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.

If you live in the state of New Jersey, the following statement applies to you:
Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

If you live in the state of Ohio, the following statement applies to you:
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.

If you live in the state of Oklahoma, the following statement applies to you:
WARNING: 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.

If you live in the states of Oregon or Virginia, the following statement applies to you:
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 may have violated state law.

If you live in the states of Tennessee or Washington, the following statement applies to you:
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.

If you live in the state of Vermont, the following statement applies to you:
Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

If you live in a state other than mentioned above, the following statement applies to you:
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.
**Long Term Disability Claim Statement—Conversion**

**INSURED’S IDENTIFYING INFORMATION**

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Full name of insured (Please print.)</td>
<td>2. Certificate number</td>
<td>3. Date of birth</td>
</tr>
<tr>
<td>4. Full address</td>
<td>5. Phone number</td>
<td>6. Social Security number</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**EMPLEYMENT INFORMATION**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>9. Name and address of employer from whose policy you converted</td>
<td>10. Occupation</td>
</tr>
<tr>
<td>11. Are you currently employed?</td>
<td>12. Current occupation</td>
</tr>
<tr>
<td>14. Name and address of current employer</td>
<td>15. Phone number</td>
</tr>
</tbody>
</table>

**DISABILITY INFORMATION**

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>16. Nature of sickness or injury (If due to accident, explain when, where and how it happened.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. Date of first medical treatment for this condition</td>
<td></td>
<td>18. Date on which you were first unable to work</td>
</tr>
<tr>
<td>If pregnancy, indicate conception and/or delivery date.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19. Have you engaged in any work, part-time or otherwise, since your sickness or injury began?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>(If “Yes,” please explain and give dates.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20. If you have recovered or returned to work, give date.</td>
<td></td>
<td>21. If still totally disabled, when do you expect to return to work?</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22. Names and addresses of all physicians who have been consulted because of this condition</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23. Have you been confined to a hospital for this disability?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>(If “Yes,” please complete.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**INSURED'S IDENTIFYING INFORMATION**

New claim ☐ Claim already submitted ☐

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Male</td>
<td>☐ Female</td>
</tr>
</tbody>
</table>

**Marital status**

- ☐ Single
- ☐ Married
- ☐ Divorced

---

Page 3 of 7
KC3283P (5/2017)
24. Are you receiving, or are you entitled to receive, benefits from any of the following sources? **Each question must be answered.**

<table>
<thead>
<tr>
<th>A. Salary, wages or commissions?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>B. Retirement or pension plan?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C. Veterans Administration</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D. Any group insurance, health or welfare plan?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>E. Workers' Compensation or similar legislation?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>F. Social Security or Railroad Retirement Act?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>G. Any federal, state, provincial, municipal or other governmental agency?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>H. No-Fault or other automobile insurance?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>I. Other sources? (Give details below.)</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

For each question answered “Yes,” please furnish the following information:

<table>
<thead>
<tr>
<th>Name and Address of source</th>
<th>Group or Individual Basis</th>
<th>Policy or Claim Number (if any)</th>
<th>Exact Date Benefits Commenced or Will Commence</th>
<th>Length of Benefit Period</th>
<th>Amount and Frequency of Each Periodic Benefit</th>
<th>Total Amount of Benefits Paid</th>
</tr>
</thead>
</table>

For Social Security, Workers’ Compensation, and other similar benefits, please furnish a copy of the benefit award (or denial letter, if applicable).

**AUTHORIZATION**

I authorize any provider of medical services, insurance company, consumer reporting agency, Social Security Administration, governmental agency, educational institute, law enforcement agency, or employer having medical information with respect to any physical or mental condition, rehabilitation and other non-medical information of me to give to Union Security Insurance Company, or its representative, any and all such information. I **understand** Union Security Insurance Company may discuss my limitations/restrictions with treating physicians and current or prospective employers as they relate to accommodations and possible return to work. I UNDERSTAND the information obtained by use of this Authorization will be used by Union Security Insurance Company to determine the eligibility for benefits. I know that a photographic copy of this authorization shall be as valid as the original. I agree this Authorization shall be valid for the duration of the claim. This authorization is not governed by HIPAA, however, when necessary, I may be asked to execute a HIPAA authorization form, allowing Union Security Insurance Company to use and disclose protected health information.

If I receive a disability benefit greater than that which I should have been paid, I understand this insurance company has the right to recover such overpayments from me, including the rights to reduce or adjust future benefits, if any.

Signature of claimant _____________________________ Date __________________

Page 4 of 7
KC3283P (5/2017)
HIPAA Authorization For Release of Protected Health Information

Insured/Member name__________________________________________SSN________________DOB________________

Address_________________________________________________________City_________________________State__________Zip__________

Policy no.______________Participation no.______________Account no.______________Certificate no.______________

Persons/categories of persons providing the information: Any provider of health care services; hospital, clinic, other medical or medically related facility; insurance or reinsuring company; pharmacist, pharmacy benefits manager, or pharmacy-related services entity; federal, state or local government agency including the Social Security Administration; consumer reporting agency; educational institute; vocational provider; accountant or tax preparer; or employer.

Persons/categories of persons receiving the information: Union Security Insurance Company or Union Security Life Insurance Company of New York ("Companies").

I hereby authorize the use or disclosure of my information as described below:

Information to be disclosed: All medical and non-medical information necessary to allow the Companies or its representatives to determine my eligibility for benefits and to process my claim. Such information may include, but is not limited to: records about my physical and mental health, including diagnosis or treatment for Human Immunodeficiency Virus (HIV), AIDS or other immune disorders, sexually transmitted diseases, use of alcohol and/or drugs; pharmacy records; records regarding Social Security benefits, Worker’s Compensation and other insurance claims and benefits, State Disability benefits, and pension benefits; earnings records; tax records and/or records regarding my employment history.

I understand the following:

• The information obtained by use of this authorization will be used by the Companies to evaluate and adjudicate my current disability claim, and may be re-disclosed to the Companies’ reinsurer(s). The Companies may release information to my treating physician and current or prospective employers relating to restrictions, accommodations and possible return to work. The information may also be released to (a) any medical, investigative, financial, vocational, or other organization or person, employed by or representing the Companies with the evaluation and adjudication of my current disability claim, (b) a Social Security vendor that may assist me in filing a claim with the Social Security Administration, and (c) other insurance companies or their representatives to help investigate and adjudicate other insurance claims related to me.

• I have the right to refuse to sign this authorization; however, if I refuse to sign this authorization, I understand that the Companies may not be able to gather the information necessary to determine if I am eligible for coverage or benefits under one of the Companies’ insurance policies. I understand that a photocopy or facsimile of this authorization is as valid as the original. Upon request, I may receive a copy of this authorization.

• This authorization is voluntary. I may revoke it at any time by writing Sun Life Financial, Privacy Office, PO Box 419052, Kansas City, MO 64141-6052. Any such revocation will not affect any actions that Companies took before receipt of the revocation.

• Federal law requires that we inform you that the information that we collect may, under certain circumstances, be re-disclosed by us to third parties and thus no longer protected by federal law.

• I understand that any information obtained by this authorization may be used and disclosed by HIPAA and non-HIPAA plans

This authorization is effective from the date signed below for 24 months.

__________________________________________
SIGNATURE OF INSURED/MEMBER OR LEGAL PERSONAL REPRESENTATIVE

__________________________________________
DATE

__________________________________________
PRINTED NAME OF LEGAL PERSONAL REPRESENTATIVE

__________________________________________
RELATIONSHIP TO INSURED/MEMBER

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

Sun Life Financial is the brand name for insurance products underwritten by Union Security Insurance Company.
The patient must pay any costs for completion of this form.

To the Attending Physician

Please read the following instructions before completing this form.

An authorization to release information can be found on pages 4 and 5.

Clearly print or type this form. Fully complete each applicable section of this form.

Sign and date this form after completion. Also, clearly print or type your name, address and phone number in the spaces provided. If applicable, include your fax number.

After you have completed this form, return the entire claim statement to the patient.

---

**Diagnoses**

<table>
<thead>
<tr>
<th>Name of patient</th>
<th>Date of birth</th>
<th>Social Security number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient's symptoms result from <em>(Check all that apply)</em>:</td>
<td>☐ Employment ☐ Illness ☐ Accident ☐ Motor Vehicle Accident ☐ Pregnancy</td>
<td></td>
</tr>
<tr>
<td>If pregnancy, <em>(expected/actual delivery date)</em></td>
<td>Type of delivery</td>
<td></td>
</tr>
<tr>
<td>Date symptoms first appeared</td>
<td>Patient's height</td>
<td>Weight</td>
</tr>
<tr>
<td>Name(s), address(es), specialty(ies) of other treating or referring physician(s)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>First visit for this condition</td>
<td>Most recent visit</td>
<td>Most recent comprehensive exam</td>
</tr>
<tr>
<td>Hospital name</td>
<td>Confinement dates</td>
<td>thru</td>
</tr>
<tr>
<td>Diagnoses with ICD9-CM codes: list in descending order of severity <em>(including any complications)</em>. Please go to the appropriate assessment section and elaborate.</td>
<td>ICD9</td>
<td></td>
</tr>
</tbody>
</table>

**Subjective symptoms**

**Objective findings**

**Functional Assessment**

In terms of an 8 hour day:

- ☐ Class 1—No limitation; capable of heavy work*—exert 50–100# occasionally and/or 25–50# force frequently.
- ☐ Class 2—Medium activity*—exert occasional 20–50# force and/or 10–25# force frequently.
- ☐ Class 3—Slight limitation; capable of light work*—exert occasional 20# force and/or up to 10# force frequently.
- ☐ Class 4—Moderate limitation; capable of sedentary*, clerical or administrative work—occasional 10# force, mostly sitting.
- ☐ Class 5—Severe limitation; incapable of minimal activity or sedentary* work. ☐ Bed confined ☐ House confined

*As defined by the U.S. Department of Labor’s Federal Dictionary of Occupational Titles

Please fully describe the patient's capabilities: *With allowance for positional change.

N=Never O=Occasionally (1/4–2 1/2 hours) F=Frequently (2 1/2–5 1/2 hours) C=Continuously (5 1/2–8 hours)

______ Standing* ______ Sitting* ______ Walking* ______ Driving* ______ Bending* ______ Data Entry*

Lifting not more than _____ pounds _______ (how often) Carry not more than _____ pounds _______ (how often)

When did these capabilities begin? ________________

Do you anticipate an increase in your patient's functional capabilities? ☐ Yes ☐ No

---

**Subjective symptoms**

**Objective findings**

**Functional Assessment**

In terms of an 8 hour day:

- ☐ Class 1—No limitation; capable of heavy work*—exert 50–100# occasionally and/or 25–50# force frequently.
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**Subjective symptoms**

**Objective findings**

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When did these capabilities begin? ________________

Do you anticipate an increase in your patient's functional capabilities? ☐ Yes ☐ No

---

**Subjective symptoms**

**Objective findings**

**Functional Assessment**

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Lifting not more than _____ pounds _______ (how often) Carry not more than _____ pounds _______ (how often)

When did these capabilities begin? ________________

Do you anticipate an increase in your patient's functional capabilities? ☐ Yes ☐ No

---

**Subjective symptoms**

**Objective findings**

**Functional Assessment**

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______ Standing* ______ Sitting* ______ Walking* ______ Driving* ______ Bending* ______ Data Entry*

Lifting not more than _____ pounds _______ (how often) Carry not more than _____ pounds _______ (how often)

When did these capabilities begin? ________________

Do you anticipate an increase in your patient's functional capabilities? ☐ Yes ☐ No
### Treatment

Describe treatment program and give dates of any surgery, medications (dosages/administration routine), physical therapy or psychotherapy.  

Frequency of treatment and/or symptoms: □ Weekly □ Monthly □ Other (Specify) ______________________

Next scheduled visit ______________________

### Cardiac

**Complete only if applicable.**

Functional capacity (American Heart Association)

- □ Class 1 (no limitation)
- □ Class 2 (slight limitation)
- □ Class 3 (marked limitation)
- □ Class 4 (complete limitation)

Blood pressure (latest reading) ______________ as of (date) ______________

METS level ______________ Date ______________ Ejection fraction ______________ % Date ______________

Is patient in a cardiac rehabilitation program?  □ Yes □ No

If “Yes,” please include dates. Start ______________ End ______________

### Psychiatric Assessment

List the patient’s DSM Code(s): ______________________

Description ____________________________________________

Please define stress as it applies to this patient.

What stress and problems in interpersonal relations has patient had on the job?

Please fully describe the patient’s limitations.

When did these limitations apply?

Began ______________ Anticipated reduction ______________ Anticipated end date ______________

### Rehab

Is patient a candidate for vocational rehabilitation services?  □ Yes (Describe) □ No (Explain)

Describe any job modifications that would aid your patient in performing his/her work tasks.

Has patient reached maximum medical improvement? □ Yes □ No □ If “No,” when? ______________ □ Unknown

### Name

Physician’s name ______________________ Degree ________ Specialty/Board certification ______________________

Address ______________________ STREET ______________________ CITY __________ STATE __________ ZIP CODE

Telephone no. ______________________ Fax no. ______________________

Signature ______________________ Date ______________

DO NOT PRE-DATE