Disability
Claim Filing
Instructions

Have you...

1. Completed the Employee’s Statement in full?
2. Had the physician treating you complete the Attending Physician’s Statement, and had it returned to you?
3. Had your Employer complete the Employer's Statement, and had it returned to you?
4. Read, signed and dated the Authorization for Release of Information?

Submit the completed statements to the address below or fax to 1-(866) 376-9480

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

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

Toll-Free Phone Number 1-(866) 376-9478

Disability RMS
One Riverfront Plaza
Westbrook, Maine 04092-9700
Disability RMS
Fax 1-(866) 376-9480
Toll Free Phone 1-(866) 376-9478

NOTICE OF CLAIM FOR □ SHORT-TERM DISABILITY BENEFITS
□ LONG-TERM DISABILITY BENEFITS

EMPLOYEE’S STATEMENT  (TO AVOID DELAY, ALL QUESTIONS MUST BE ANSWERED)

<table>
<thead>
<tr>
<th>NAME OF EMPLOYEE</th>
<th>EMPLOYEE’S SOCIAL SECURITY -</th>
</tr>
</thead>
<tbody>
<tr>
<td>EMPLOYEE’S STREET &amp; NO.</td>
<td>CITY</td>
</tr>
<tr>
<td>TELEPHONE NO.</td>
<td>DATE OF BIRTH</td>
</tr>
<tr>
<td>RIGHT-HANDED</td>
<td>LEFT-HANDED</td>
</tr>
<tr>
<td>LIST NAMES AND DATES OF BIRTH OF SPOUSE AND DEPENDENT CHILDREN</td>
<td></td>
</tr>
</tbody>
</table>

HOW MANY HOURS WERE YOU REGULARLY WORKING PER WEEK WITH YOUR PRESENT EMPLOYER? ______ hrs.

GROSS ANNUAL SALARY: (During the 12 months just prior to your disability - for this employer only) $ ____________

PLEASE INDICATE HOW YOU ARE PAID:
□ 9 MOS./YR.  □ 10 MOS./YR.  □ 12 MOS./YR.  □ OTHER _______________________

NAME OF EMPLOYER | EMPLOYER’S TELEPHONE NO. ( ) -
| EMPLOYER’S STREET & NO. | CITY | STATE | ZIP |

YOUR OCCUPATION & TITLE |

LIST ESSENTIAL DUTIES OF YOUR JOB AT THE TIME OF DISABILITY |

DATE OF INJURY OR DATE FIRST NOTICED SYMPTOMS OF SICKNESS / /

YOU HAVE BEEN UNABLE TO WORK BECAUSE OF DISABILITY SINCE: / /

YOU RETURNED TO WORK ON A PART-TIME BASIS ON: / /

YOU RETURNED TO WORK ON A FULL-TIME BASIS ON: / /

IS YOUR INJURY OR SICKNESS RELATED TO YOUR OCCUPATION? □ YES □ NO

IF "YES", EXPLAIN:

DID YOU FILE FOR WORKERS’ COMPENSATION? □ YES □ NO

DESCRIBE HOW AND WHERE INJURY OCCURRED OR DESCRIBE THE ONSET AND NATURE OF YOUR MEDICAL CONDITION INCLUDING SYMPTOMS. IF MORE SPACE IS NEEDED, PLEASE ATTACH SHEET OF PAPER.

DATE FIRST TREATED / /

IF "HOSPITAL CONFINED", GIVE NAME AND ADDRESS OF HOSPITAL

HOSPITAL: ___________________________

CONFINED FROM ____________ THROUGH ____________

HAVE YOU EVER HAD THE SAME OR SIMILAR CONDITION IN THE PAST? □ YES □ NO

IF "YES", WHEN? ___________________________

TREATED BY:

HOSPITAL: ___________________________

DOCTOR: ___________________________

Name | Street Address | City | State | Zip

Name | Street Address | City | State | Zip

PLEASE COMPLETE BOTH SIDES OF THIS FORM
FOR PREGNANCY DISABILITY ONLY:
Are there any present complications or anticipated difficulties in connection with the following?

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

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

c. Post Partum ☐ YES ☐ NO

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

As a result of this disability, are you, your spouse or any of your dependent children receiving income from any of the following?

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

HAVE YOU APPLIED, OR DO YOU PLAN TO APPLY FOR BENEFITS DESCRIBED ABOVE? ☐ YES ☐ NO

TYPE ________________________ DATE APPLICATION FILED ________________________

FAKE NOTICE

Unless specific state language is provided below, and unless you reside in Virginia, the following general fraud notice applies: Any person who knowingly, and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and subjects such person to criminal and civil penalties.

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

Arkansas, Louisiana, New Mexico, West Virginia - Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

California - For your protection California law requires the following 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."

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

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

Kentucky - Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maine, Tennessee - It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

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

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

New Jersey - Any person who knowingly files a statement of claim containing any false or misleading information is subject to prosecution and punishment for insurance fraud.

New York - Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Signature of Employee __________________________ Date _______________
AUTHORIZATION FOR RELEASE OF INFORMATION (excluding psychotherapy notes)  
(HIPAA Compliant)  
(to be signed and dated by the insured/claimant)  

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

This authorization is valid during the pendency of my claim and shall expire on the date my claim finally ends. A photocopy of this authorization is as valid as the original. I understand that my authorized representative or I have the right to request and receive a copy of this authorization and the information to which it pertains.

I understand that I have the right to revoke this authorization by notifying Disability RMS in writing, of my revocation. However, such revocation is not effective to the extent that Disability RMS and/or Union Security Insurance Company have relied previously upon this authorization for the use or disclosure of my protected health information. In addition, I understand that my revocation of, or my failure to sign this authorization may impair Disability RMS' and Union Security Insurance Company's ability to evaluate my current disability claim and as a result may be a basis for denying that current disability claim for benefits.

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

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

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

Claimant Signature (or Authorized Representative)___________________________ Date: __________

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

- **SHORT-TERM DISABILITY BENEFITS**
- **LONG-TERM DISABILITY BENEFITS**

---

### EMPLOYER’S OR ADMINISTRATOR’S STATEMENT

**ALL QUESTIONS MUST BE ANSWERED TO AVOID DELAY**

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

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

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

<table>
<thead>
<tr>
<th>REQUIRED NUMBER OF HRS. PER WEEK</th>
<th>GROSS ANNUAL SALARY: (During the 12 months just prior to your employee’s disability)</th>
</tr>
</thead>
<tbody>
<tr>
<td>___________ hrs.</td>
<td>$ ________________________</td>
</tr>
</tbody>
</table>

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

**PERCENTAGE OF EMPLOYEE/EMPLOYER CONTRIBUTION TO PREMIUM FOR THIS DISABILITY PLAN**

(AS OF POLICY YEAR OF DISABILITY)

<table>
<thead>
<tr>
<th>EMPLOYEE</th>
<th>☐ 100% ☐ OTHER __________% IS EMPLOYEE CONTRIBUTION:</th>
<th>☐ PRE-TAX DEDUCTION?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ 100%</td>
<td>☐ OTHER __________%</td>
<td>☐ AFTER-TAX DEDUCTION?</td>
</tr>
</tbody>
</table>

**EMPLOYEE ELIGIBLE FOR:**

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
<th>TYPE</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
<td>Sick Pay</td>
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<td>☐</td>
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<td>Salary Continuance Benefits</td>
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<td>No-fault</td>
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<td>Other LTD/STD Benefits</td>
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<tr>
<td>☐</td>
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<td>Other (describe)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>AMOUNT</th>
<th>DATE BEGAN</th>
<th>DATE TERM.</th>
<th>PAID WEEKLY</th>
<th>PAID MONTHLY</th>
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</tbody>
</table>

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

- The employee’s Workers’ Compensation claim(s) and Approval/Denial Notification
- The employee’s prior year’s W-2 form OR if no W-2 is available, list the basic monthly earnings for the past 12 months just prior to the employee’s date of disability
- The employee’s current job description

**Unless you reside in Virginia, the following general fraud notice applies:** Any person who knowingly, and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and subjects such person to criminal and civil penalties.

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

---

**NAME OF POLICYHOLDER (COMPANY)**

**PRINT NAME & TITLE OF OFFICIAL REPRESENTATIVE**

**MAILING ADDRESS OF POLICYHOLDER (COMPANY)**

**SIGNATURE**

**DATE**

**TELEPHONE NUMBER**

**FAX NUMBER**

---

**PLEASE RETURN THIS COMPLETED FORM TO THE EMPLOYEE**

---
ATTENDING PHYSICIAN’S STATEMENT - THIS STATEMENT MUST BE FILLED-IN COMPLETELY BY A PHYSICIAN
(Please Print or Type)

<table>
<thead>
<tr>
<th>Name of Patient</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>FIRST</td>
<td>MIDDLE</td>
</tr>
<tr>
<td>Blood Pressure (last visit)</td>
<td>/ /</td>
</tr>
<tr>
<td>Height</td>
<td>Weight</td>
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<tr>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>Left-handed</td>
<td>Right-handed</td>
</tr>
</tbody>
</table>

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

2. DIAGNOSIS:
   a. Diagnosis impacting function: ___________________________ ICD9 Code(s) ___________________
      Nature of treatment (including surgery and medications prescribed, if any, including dosage and frequency) ___________________________
   b. Secondary diagnosis impacting function: ___________________________
      Nature of treatment (including surgery and medications prescribed, if any, including dosage and frequency) ___________________________
   c. Subjective symptoms: ___________________________
   d. Objective findings (including current X-rays, EKGs, Laboratory Data and any clinical findings): ___________________________

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

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

5. PROGRESS:
   If "Hospital Confined", give Name and Address of Hospital ___________________________
   Confined from __________________ through __________________

PLEASE COMPLETE BOTH SIDES OF THIS FORM
6. CARDIAC (if applicable)

Functional Capacity
- Class 1 (No limitation) ☐
- Class 2 (Slight limitation) ☐
- Class 3 (Marked limitation) ☐
- Class 4 (Complete limitation) ☐

(American Heart Assoc. standards)

7. CURRENT FUNCTIONAL ABILITY

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

   ___ Hrs.  Sedentary Activity
   10 lbs. maximum lifting or carrying articles. Walking/standing on occasion. Sitting 6 to 8 hours.

   ___ Hrs. Light Activity
   20 lbs. maximum lifting, carrying 10 lbs. articles frequently, most jobs involving standing with a degree of pushing and pulling. Standing 6 to 8 hours.

   ___ Hrs. Medium Activity
   50 lbs. maximum lifting with frequent lifting/carrying of up to 25 lbs. Frequent walking and standing.

   ___ Hrs. Heavy Activity
   100 lbs. maximum lifting, frequent lifting/carrying of up to 50 lbs. Frequent walking and standing.

b. Please check appropriate box:

   - Bending
   - Climbing
   - Reaching
   - Kneeling
   - Squatting
   - Crawling
   - Push/pull
   - Lifting (lbs.)

   Numb. of lbs.

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

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

   ____________________________________________
   ____________________________________________
   ____________________________________________

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

   - Simple grasp
   - Pinch
   - Fine manipulation
   - Power grip
   - Repetitive motion

   Left  Right

   Comments

8. MENTAL HEALTH ABILITY (if applicable)

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

   ____________________________________________
   ____________________________________________
   ____________________________________________

9. RETURN TO WORK PLAN

a. Have you discussed a return to work plan with your patient?  ☐ Yes  ☐ No

b. The date you released patient to return to work: ______/_______/______

   □ Full-time  ☐ Reduced hours  Number of hours: __________

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

   ____________________________________________
   ____________________________________________

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ATTENDING PHYSICIAN’S SIGNATURE __________________________________________________________________________ DATE _________________

PHYSICIAN’S NAME (PLEASE PRINT) __________________________________________________________________________

DEGREE/SPECIALTY ___________________________________________________________________________________________

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

OFFICE ADDRESS _______________________________________________________________________________________________

NUMBER/STREET ____________________________________________________________

CITY OR TOWN __________________________ STATE __________ ZIP CODE __________________________

PLEASE RETURN COMPLETED FORM TO YOUR PATIENT/THE EMPLOYEE