

Please return to:  
CBIA Insurance Operations  
350 Church Street, Hartford, CT 06103  
fax: 860-278-0883

**HARTFORD LIFE INSURANCE COMPANY  
HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY**

**APPLICATION FOR LONG TERM DISABILITY INCOME BENEFITS**

This application package is divided into four sections, as follows:

- Section 1    Employer' Statement** - to be completed by the employer's authorized representative. Be sure to provide any necessary attachments see section K).
- Section 1c    Information for Group Life Premium Waiver Benefits** - to be completed by the employer's authorized representative if the employer also has a Group Life Insurance policy with The Hartford that includes a Premium Waiver benefit. Be sure to provide any necessary attachments (see Section K).
- Section II    Employee's Statement** - to be completed by the employee who is applying for Long Term Disability benefits. Please attach a copy of the employee's driver's license.
- Section III    Authorization to Obtain Information** - to be signed by the employee.
- Section IV    Attending Physician's Statement** - to be completed by the physician who is treating the employee.

**PLEASE SEE THAT ALL SECTIONS ARE FULLY COMPLETED AND SIGNED. FORWARD THE COMPLETED APPLICATION TO YOUR HARTFORD BENEFIT MANAGEMENT SERVICE CENTER.**

APPLICATION FOR LONG TERM DISABILITY INCOME BENEFITS  
**HARTFORD LIFE INSURANCE COMPANY**  
**HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY**

**Section 1**  
**Employer's Statement**

**To be Completed by the Employer**

This claim is for ( <i>Employee's Name</i> )	Social Security Number	Date of Birth
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Employee's Address (*Street, City, State, Zip*)

**A. Information About the Employer**

Company's Name <b>CBIA Service Corp.</b>	Group Policy Number <b>GRH-703586</b>
Address ( <i>Street, City, State, Zip</i> )	Telephone Number
Name and address of division where employee works ( <i>if different from above</i> )	Fax Number

**B. Information About the Employee**

Date employee was hired	Date employee became insured under this plan	What was the employee's regularly scheduled work week? _____ hours per week
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Was the employee's LTD insurance issued on the basis of a Personal Health Statement?  Yes  No If "Yes," attach copy.

Was the employee insured under your prior LTD policy?  Yes  No  
 If "Yes," please provide the inclusive date of coverage. From \_\_\_\_\_ Through \_\_\_\_\_

Has the employee been terminated?  Yes  No If "Yes," date: \_\_\_\_\_  
 Reason: \_\_\_\_\_

Was the employee on Qualified Family Leave when disability began?  Yes  No  
 Did LTD insurance continue while on Family Leave?  Yes  No  
 Date leave of Absence started under Family Leave Act \_\_\_\_\_

**C. Information for Group Life Premium Waiver Benefits**

Does the employee also have Group Life Insurance coverage with the Hartford?  
 Yes  No If "Yes," provide the following information:

Basic Amount \$ \_\_\_\_\_  
 Supplemental Amount \$ \_\_\_\_\_  
 Effective Date of Group Life Insurance coverage \_\_\_\_\_

**D. Information Needed for Withholding and Reporting Taxes**

Based on the employer/employee premium contributions made over the last 3 years, what percentage of the LTD benefits is considered taxable? \_\_\_\_\_%. (*See Section 7 of IRS Publication 15-A for information on determining the taxable percentage.*)

**E. Information About the Claim**

Were there any changes to the employee's job responsibilities due to the disabling condition before the employee became totally 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?
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Last day employee actually worked	On that day, did the employee work a full day? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No," how many hours were worked? _____
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Why did employee stop working?	Is the employee's condition work related? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Has a claim been filed with Workers' Compensation? <input type="checkbox"/> Yes <input type="checkbox"/> No if "Yes," send initial report of illness or injury and award notice.	Date employee is expected/did return to work _____ Full time? <input type="checkbox"/> Yes <input type="checkbox"/> No ( <i>Month, Day, Year</i> )
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Name and address of your compensation carrier

**F. Information About Your Pension Plan** (*Do not complete for maternity claim.*)

Do you have a pension plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	If "Yes," what type? ( <i>check as many as applicable</i> )	<input type="checkbox"/> Defined benefit <input type="checkbox"/> 401K <input type="checkbox"/> Other (specify) <input type="checkbox"/> Defined contribution <input type="checkbox"/> Profit Sharing
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Is the employee eligible for your pension plan? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No," why?	If eligible, does the employee participate? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No," why?
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If the employee is participating, when is he or she eligible for benefits under the plan? \_\_\_\_\_  
 (*Month, Day, Year*)

At what point does the employee qualify for a full pension? \_\_\_\_\_

Is there a disability Retirement Option available to this employee?  Yes  No

**G. 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?

**H. Information About the Employee's Salary**

Basic Salary or wage immediately prior to cessation of work because of disability (exclude bonuses, overtime pay, etc.)

\$ \_\_\_\_\_  Monthly  Weekly  Annually  Hourly # Hours/Week \_\_\_\_\_

Is this employee eligible for salary continuation?

Yes  No If "Yes," what is the weekly amount \$ \_\_\_\_\_ When do benefits begin? \_\_\_\_\_ End? \_\_\_\_\_

Will the employee file for Short Term or State Disability benefits?

Yes  No If "Yes," what is the weekly amount \$ \_\_\_\_\_ When do benefits begin? \_\_\_\_\_ End? \_\_\_\_\_

List any other sources of income to which the employee is entitled as a result of this disability:

**I. 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:

- Not Applicable** means the person does not perform this activity.
- 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			
	N/A	Occasionally	Frequently	Continuously
<input type="checkbox"/> Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Sitting	<input type="checkbox"/>	<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"/>
<input type="checkbox"/> Stooping	<input type="checkbox"/>	<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"/>
<input type="checkbox"/> Crouching	<input type="checkbox"/>	<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"/>
<input type="checkbox"/> Reaching/working overhead	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Keyboard Use/Repetitive Hand Motion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Climbing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Activity	Description	Frequency	Weight
<input type="checkbox"/> Pushing	_____	_____	_____ lbs.
<input type="checkbox"/> Pulling	_____	_____	_____ lbs.
<input type="checkbox"/> Lifting	_____	_____	_____ lbs.
<input type="checkbox"/> Carrying	_____	_____	_____ lbs.

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

What are the major tasks requiring the use of one or both hands? Indicate the percentage of the employee's workday that is spent on each of these tasks.

_____	_____ %
_____	_____ %
_____	_____ %

**J. 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 (e.g., through the use of technology or personal assistance)?  Yes  No If "Yes," explain.

**K. Required Attachments and Signature**

- Please attach a copy of the employee's job description.
- If the employee contributes to the premiums for LTD or Group Life Insurance coverage, attach a copy of the enrollment form and/or copies of the last two Flexible Benefits Election forms.
- 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 or 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 copy to you).

Name (Please print or type)

Title

Signature

Date

APPLICATION FOR LONG TERM DISABILITY INCOME BENEFITS  
**HARTFORD LIFE INSURANCE COMPANY**  
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**Section II**  
**Employee's Statement**

**To be Completed by the Employee (BE SURE TO ANSWER ALL QUESTIONS — FAILURE TO DO SO MAY DELAY YOUR CLAIM)**

**A. Information About You**

Last name	First	Middle Initial	Social Security Number
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Address (Street)	City	State/Province	ZIP
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Telephone Number \_\_\_\_\_

Date of Birth (Month, Day, Year)	Height	Weight	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Single <input type="checkbox"/> Married	<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced
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Your employer (include division, if applicable)	Occupation
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When your disability began, did you have more than one employer (includes self-employment)?  Yes  No. If "Yes," please provide the name, address and phone number of that employer. Indicate the dates when you worked (or were self-employed).

Please indicate the extent of your formal education (Circle one)

High School: 1 2 3 4 5 6 7 8 9 10 11 12

College: 1 2 3 4

Masters \_\_\_\_\_ Ph.D. \_\_\_\_\_

Trade School: \_\_\_\_\_

Briefly describe your past work experience for the last 20 years (Begin with your most recent job.)

Job Title	Duties	Years Worked
(a)		
(b)		
(c)		
(d)		

Now, or at some time in the future, would you be interested in seeking rehabilitation to some other kind of work?  
 Yes  No

Have you contacted your State Department of Vocational Rehabilitation?

Yes  No If "Yes," please include the name, address and telephone number of your counselor.

**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? <input type="checkbox"/> Yes <input type="checkbox"/> No	Retired? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Do you have any children under Age 19?

Yes  No If "Yes," name and date of birth of each child

Do you have any children with disabilities (regardless age)?

Yes  No If "Yes," name and date of birth of each child

**C. Information About the Condition Causing Your Disability**

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

What were your first symptoms?

When did you first notice them?

Have you had this illness before? If so, when?

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

When, where and how did the injury occur?

**3. For Illness, Injury or Pregnancy, answer the following questions:**

Date you were first treated by a physician?

Name of Physician \_\_\_\_\_

\_\_\_\_\_  
(Month, Day, Year)

Address of Physician \_\_\_\_\_

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 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

**D. Information About the Disability**

Last day you worked before the disability

Did you work a full day?  Yes  No  
If "No" explain.

Date you were first unable to work

\_\_\_\_\_  
(Month, Day, Year)

\_\_\_\_\_  
(Month, Day, Year)

Since that date, have you done any work?  Yes  No

If "Yes," please indicate dates worked, name of employer, and amount earned.

If you have not returned to work, do you expect to?

Yes Part time (date) \_\_\_\_\_ Full time (date) \_\_\_\_\_  
 No

**E. Information About Physicians and Hospitals**

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

Doctor's Name

Telephone

Specialty

FAX: ( )

Address (Street, City, State, Zip)

Dates seen  
to

**List all Physicians and Hospitals you have seen for this condition (attach separate sheet, if needed)**

Doctor's Name

Telephone

Specialty

FAX: ( )

Address (Street, City, State, Zip)

Dates seen  
to

Hospital

Address (Street, City, State, Zip)

Dates of Confinement  
to

Have you consulted any other physicians or been hospitalized in the past three years?  Yes  No

If "Yes," complete the following concerning your past treatment (attach separate sheet, if needed)

Doctor's Name

Telephone

Specialty

FAX: ( )

Address (Street, City, State, Zip)

Dates seen  
to

Hospital

Address (Street, City, State, Zip)

Dates of Confinement  
to

**APPLICATION FOR LONG TERM DISABILITY INCOME BENEFITS**

**F. Other Income**

**Check the other income benefits you have received/are receiving, or are eligible to receive during your disability (complete the information requested).**

<u>Source of Income</u>	<u>Amount (week/month)</u>	<u>Date Claim was filed</u>	<u>Date Payments began</u>	<u>Date Payments ended</u>
Social Security/Retirement	\$ ___/ _____	_____	_____	_____
Social Security/Disability	\$ ___/ _____	_____	_____	_____
Sick Pay or Salary Continuation	\$ ___/ _____	_____	_____	_____
Income from Work	\$ ___/ _____	_____	_____	_____
Workers' Compensation	\$ ___/ _____	_____	_____	_____
State Disability	\$ ___/ _____	_____	_____	_____
Pension/Retirement	\$ ___/ _____	_____	_____	_____
Pension/Disability	\$ ___/ _____	_____	_____	_____
Short Term Disability	\$ ___/ _____	_____	_____	_____
Unemployment	\$ ___/ _____	_____	_____	_____
No-Fault Insurance	\$ ___/ _____	_____	_____	_____
Other (include Individual or Group Benefits)	\$ ___/ _____	_____	_____	_____

**G. Information about Tax Withholding**

Federal law requires us to withhold federal income tax from your check **if you request us to do so**. We are also required to send a report to your employer at the end of each calendar year showing your name, total amount of benefits paid to you, total amount withheld, if any, and your social security number. If you want us to withhold tax, please indicate on the line below the dollar amount to be withheld per benefit check. Whole dollars only (*minimum is \$87.00 per month*): \$ \_\_\_\_\_.

APPLICATION FOR LONG TERM DISABILITY INCOME BENEFITS

H. Signature

With the exception of any source(s) of income reported above in Section F of this form, I certify by my signature that I have not and am not eligible to receive any source of income, except for my Hartford Disability Income. Further, I understand that should I receive income of any kind or perform work of any kind during any period The Hartford has approved my disability claim, I must report all details to The Hartford, immediately.

If I receive disability benefits greater than those which should have been paid, I understand that I will be required to provide a lump sum repayment to the insurance company. The insurance company has the option to reduce or eliminate future disability payments in order to recover any overpayment balance that is not reimbursed.

**For residents of all states EXCEPT California, Florida, New Jersey, Colorado, Pennsylvania, Arkansas, New Mexico, Louisiana, Oregon and Virginia:** 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.** 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, New Mexico and Louisiana:** 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 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 Pennsylvania:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement or 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 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.

The statements contained in this application for Long Term Disability Income Benefits are true and complete to the best of my knowledge and belief.

X \_\_\_\_\_ X \_\_\_\_\_  
SIGNATURE OF THE EMPLOYEE DATE

PLEASE ATTACH A COPY OF YOUR DRIVER'S LICENSE OR ANOTHER DOCUMENT THAT VERIFIES YOUR DATE OF BIRTH.

Authorization to Obtain and Release Information

TO: Any physician, medical practitioner, hospital, pharmacy, clinic or other medical or medically-related facility or provider of medical or dental services or supplies; any employer, group policyholder, contract holder or insurer, benefit plan administrator, Medical Information Bureau, Inc., Health Claims Index, The Index System, business entities, financial institutions, consumer reporting agencies, educational institutions, or any Federal, state or Local Government Agency, including social Security Administration and Veterans Administration.

I authorize you to release and send to: (i) Hartford Fire Insurance Company, Hartford Life Insurance Company, Hartford Life and Accident Insurance Company, and any affiliate of one or more of these three companies, known collectively as The Hartford; or (ii) The Hartford's representatives, a complete copy of any and all of the following information, records or documents relative to

\_\_\_\_\_ Insured's Name (Please print.)

\_\_\_\_\_ (Date of Birth) \_\_\_\_\_ (Social Security Number)

- 1. Any and all medical information, including x-ray films, photocopies of medical records, medical histories, physical, mental, or diagnostic examinations, and treatment notes. For purposes of this authorization, medical information specifically includes confidential information regarding HIV/AIDS, communicable diseases, alcohol or drug abuse, and mental health, as such information may relate to my claim for benefits.
2. Work information and history, including, but not limited to, job duties, earnings and personnel records, client lists, any and all other work-related information for contractual work performed; information on any insurance coverage and claims filed, including all records and information related to such coverage and claims; credit information, including, but not limited to, credit reports and credit applications; other financial information, e.g., bank records; business transactions or any kind or description, including billing, invoices or payment records of any kind; and academic transcripts.
3. Information concerning Social Security benefits, including, but not limited to, monthly benefit amounts, monthly payment amounts, entitlement dates, and information from my Master Beneficiary Record.

I further authorize The Hartford or its reinsurers to request a report from the Medical Information Bureau (MIB), which is an association of life insurance companies that operates the Health Claim Index (HCI) on behalf of subscriber insurers. I understand that The Hartford may also send a brief report to HCI. An HCI report includes the dates of claims filed for or by me, claim date of loss and the names of companies to which claims were submitted, but does not contain medical information. Upon receipt of a request from me, MIB will arrange disclosure of any information it may have in my HCI file. If I question the accuracy of information in the file, I may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB, Inc.'s information office is Post Office Box 105, Essex Station, Boston, MA 02 112, telephone number (617) 426-3660.

I understand that the information obtained by use of the Authorization will be used for the purpose of evaluating and administering a claim for benefits. Any information obtained will not be released by The Hartford to any person or organization EXCEPT to reinsuring companies or their representatives. The Index System, Medical Information Bureau, Health Claim Index, physicians who have treated me, or other persons or organizations performing business or legal services in connection with my Claim, or as may be otherwise lawfully required, or as I may further authorize, or as may be necessary to prevent or to detect the perpetration of a fraud.

I know that I may request to receive a copy of this Authorization.

This Authorization is given in connection with a claim for benefits. I intend that it be valid for the duration of the claim.

A photocopy or facsimile of this authorization shall be valid as the original.

Signature of Insured or Guardian

Relationship to Insured (if signed by Guardian)

Date

Continued on back

ATTENDING PHYSICIAN'S STATEMENT OF DISABILITY

To be completed by the Employee

Name of patient \_\_\_\_\_ Social Security Number \_\_\_\_\_ D.O.B. \_\_\_\_\_

Address of patient \_\_\_\_\_  
Street City State or Province Zip Code or Postal Code

Employer's name (and division, if applicable) \_\_\_\_\_

I hereby authorize release of information on this form by the below \_\_\_\_\_ Signed (Patient) \_\_\_\_\_  
named physician for the purpose of claim processing. \_\_\_\_\_ Date: \_\_\_\_\_

To be completed by the Attending Physician (The patient is responsible for the completion of this form without expense to the Company.)

Patient's condition is the result of:  Illness  Injury  Pregnancy Height \_\_\_\_\_ Weight \_\_\_\_\_

If pregnancy, what is the expected date of delivery? Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

Is condition due to illness or an injury that is work related?  Yes  No

DIAGNOSIS

Primary diagnosis: \_\_\_\_\_ ICD-9 Code: \_\_\_\_\_

Secondary diagnosis(es): \_\_\_\_\_ ICD-9 Code(s): \_\_\_\_\_

Subjective symptoms: \_\_\_\_\_

Test Results (list all results, or enclose test):

Test: \_\_\_\_\_ Date: \_\_\_\_\_ Results: \_\_\_\_\_

Test: \_\_\_\_\_ Date: \_\_\_\_\_ Results: \_\_\_\_\_

Physical examination findings: \_\_\_\_\_

If pregnancy, indicate LMP date: \_\_\_\_\_ Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

TREATMENTS

Date you first treated this patient: \_\_\_\_\_ Date you first treated this patient for this condition: \_\_\_\_\_

Date of onset of this condition: \_\_\_\_\_ Date of most recent treatment: \_\_\_\_\_

How often has patient been seen/treated? \_\_\_\_\_ Date of next office visit: \_\_\_\_\_

Has patient been referred to any other physician?  Yes  No if "Yes," Date(s) \_\_\_\_\_

Name and address: \_\_\_\_\_

Speciality: \_\_\_\_\_

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," Date(s) admitted: \_\_\_\_\_ Date(s) discharged: \_\_\_\_\_

Name and address of hospital(s): \_\_\_\_\_

Progress (Please check one.):  Recovered  Improved  Unchanged  Retrogressed

APPLICATION FOR LONG TERM DISABILITY INCOME BENEFITS

ATTENDING PHYSICIAN'S STATEMENT OF DISABILITY (Side two)

IMPAIRMENT

If the patient's ability to perform any of the following activities is limited by his/her disorder, please describe the extent of the limitation and its expected duration.

Standing: \_\_\_\_\_

Walking: \_\_\_\_\_

Sitting: \_\_\_\_\_

Lifting/carrying: \_\_\_\_\_

Reaching/working overhead: \_\_\_\_\_

Pushing: \_\_\_\_\_

Pulling: \_\_\_\_\_

Driving: \_\_\_\_\_

Keyboard use/repetitive hand motion: \_\_\_\_\_

If any other activities are limited, please specify the activities and the limitations: \_\_\_\_\_

If the patient's vision is impaired, please describe the extent of the impairment: \_\_\_\_\_

Do you believe the patient is competent to endorse checks and direct the use of the proceeds thereof?  Yes  No

What is the psychiatric impairment (if applicable)?

- Inadequate information to make assessment.
 Essentially good functioning in all areas. Occupationally and socially effective.
 Slight difficulty in occupational functioning, but generally functioning well. Has some meaningful interpersonal relationships.
 Moderate impairment in occupational functioning. Limited in performing some occupational duties.
 Major impairment in several areas -- work, family relations. Avoidant behavior, neglects family, is unable to work.
 Inability to function in almost all areas.

Date patient became unable to work due to this impairment? Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

If physical or psychiatric limitations exist, how long do you feel limitations will last? \_\_\_\_\_

Attending Physician's Name: \_\_\_\_\_ Telephone # \_\_\_\_\_
(Please print or type.)

License No. \_\_\_\_\_ FAX # \_\_\_\_\_

SS# or E.I.N.#: \_\_\_\_\_ Degree: \_\_\_\_\_ Specialty: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Signature: \_\_\_\_\_ Date signed: \_\_\_\_\_