



P.O. Box 100102
Columbia, SC 29202-3102

ATTENDING PHYSICIAN'S STATEMENT

WAIVER OF
PREMIUM

FOR OFFICE USE ONLY
APPROVED _____
DATE _____

The Patient is responsible for the completion of this form without expense to the company.
Space is available on the reverse side if you wish to amplify your answers.

FRAUD WARNING (Not Applicable in FL, MD, or OR):

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 thereto commits (in TX, may be committing) a fraudulent insurance act, which is a crime and subjects (in KS, which may be determined by a court of law to be a crime which subjects) such person to criminal and civil penalties.

FRAUD WARNING (FL Only):

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.

Name of Patient _____ Phone _____ Date of Birth ____/____/____

Employer Name _____ Phone _____ Policy No. _____

1. HISTORY

- (a) When did symptoms first appear or accident happen? Mo. _____ Day _____ 20 ____
- (b) Date patient ceased work because of disability Mo. _____ Day _____ 20 ____
- (c) Has patient ever had same or similar condition? Yes No If "Yes" state when and describe

2. DIAGNOSIS (including any complications): _____

- (a) Date of last examination Mo. _____ Day _____ 20 ____
- (b) Diagnosis (including any complications)
- (c) Objective finding (including current X-rays, EKG's, Laboratory Data and any clinical findings)

3. DATES OF TREATMENT

- (a) Date of first visit. Mo. _____ Day _____ 20 ____
- (b) Date of last visit. Mo. _____ Day _____ 20 ____
- (c) Frequency Weekly Monthly Other (Specify) _____

4. NATURE OF TREATMENT (including any complications)

5. PROGRESS

- (a) Has patient. Recovered? Improved? Unchanged? Retrogressed?
- (b) If recovered, date able to resume work. _____ Mo. / _____ Day / _____ Yr.
- (c) Is patient. Ambulatory? House Confined?
Bed Confined? Hospital Confined?
- (d) Has patient been hospital confined? Yes No If yes, give Name and Address of Hospital _____
_____ Confined from _____ Through _____

6. CARDIAC (If Applicable)

- (a) Functional capacity Class 1 (No limitation) Class 2 (Slight limitation)
(American Heart Association) Class 3 (Marked limitation) Class 4 (Complete limitation)
- (b) Blood Pressure (last visit) _____ / _____
SYSTOLIC / DIASTOLIC

7. PHYSICAL IMPAIRMENT (*as defined in Federal Dictionary of Occupational Titles)

- Class 1** – No limitation of functional capacity; capable of heavy work* No restrictions. (0-10%)
- Class 2** – Medium manual activity* (15-30%)
- Class 3** – Slight limitation of functional capacity; capable of light work* (35-55%)
- Class 4** – Moderate limitation of functional capacity; capable of clerical/administrative (sedentary*) activity. (60-70%)
- Class 5** – Severe limitation of functional capacity; incapable of minimal (sedentary*) activity. (75-100%)
- Remarks:**

8. MENTAL/NERVOUS IMPAIRMENT (If applicable)

(a) Please define "stress" as it applies to this claimant.

(b) What stress and problems in interpersonal relations has claimant had on job?

- Class 1** – Patient is able to function under stress and engage in interpersonal relations (no limitations)
- Class 2** – Patient is able to function in most stress situations and engage in most interpersonal relations (slight limitations)
- Class 3** – Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations (moderate limitations)
- Class 4** – Patient is unable to engage in stress situations or engage in interpersonal relations (marked limitations)
- Class 5** – Patient has significant loss of psychological, physiological, personal and social adjustment (severe limitations)
- Remarks:**

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

9. PROGNOSIS

- (a) Is patient now totally disabled from performing HIS/HER REGULAR JOB? Yes No
- (b) Is patient now totally disabled from performing ALL OTHER TYPES OF WORK? Yes No
- (c) Do you expect any significant improvement in the future? Yes No
- (1) If yes, when will patient recover sufficiently to perform the duties of:
 - (a) HIS/HER REGULAR JOB / / 1 Mo. 1-3 Mos.
 - Mo. Day Yr. 3-6 Mos. Never
 - (b) ANY OTHER TYPE OF WORK / / 1 Mo. 1-3 Mos.
 - Mo. Day Yr. 3-6 Mos. Never
- (2) If no, please explain.....
- (3) If patient only PARTIALLY Disabled, please give dates of partial disability. From _____ To _____

10. REHABILITATION

- (a) Is patient a suitable candidate for further rehabilitation services? (i.e., cardiopulmonary program, speech therapy, etc.) Yes No
- (b) Can present job be modified to allow for handling with impairment? Yes No
- (c) When could trial employment commence.....

	PATIENT'S JOB.		ANY OTHER WORK
<u> </u> / <u> </u> / <u> </u>	Full-time <input type="checkbox"/> . .	<u> </u> / <u> </u> / <u> </u>	Full-time <input type="checkbox"/>
Mo. Day Yr.	Part time <input type="checkbox"/> . .	Mo. Day Yr.	Part-time <input type="checkbox"/>
- (d) Would vocational counseling and/or retraining be recommended? Yes No

11. REMARKS

Name (Attending Physician) Print	Degree	Telephone
Street Address	City or Town	State or Province
Signature	Date	
		Zip Code



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Columbia, SC 29202-3102

By furnishing this blank and investigating the claim the company shall not be held to admit the validity of any claim or to waive the breach of any condition of the policy.

Completed form should be returned to the Claims Department

Part I TO BE COMPLETED BY EMPLOYER OR PLAN ADMINISTRATOR

	Group Policy Number	Certificate Number	Social Security Number
1. Name of Insured	Insurance Class	Amount of Insurance \$	
2. Address	Phone	Date of Birth	Month Day Year
3. Date on which total disability began	Month Day Year	Cause of disability	
4. Do you expect Insured to return to work?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If "Yes", give approximate or estimated date	
5. Date Employed	Month Day Year	Job Description and Duties	
6. Date on which the Insured last worked full time	Month Day Year	REASON	
7. Has this employee or member's insurance been terminated?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If "Yes", show date of termination:	Month Day Year
		Has this employee or member's insurance been converted? <input type="checkbox"/> Yes <input type="checkbox"/> No	
8. IF GROUP POLICY ISSUED TO A UNION OR TRUSTEE PLAN, PLEASE ANSWER THE FOLLOWING QUESTIONS:			
a. Date on which the insured became a member _____			
b. Date on which the insured terminated membership _____			
c. Was the insured a member in good standing on the date disability began? <input type="checkbox"/> Yes <input type="checkbox"/> No			
9. Do you recommend payment of this claim? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Remarks:			
Date	Name of Group Policyholder	By	Title Phone

Part II TO BE COMPLETED BY EMPLOYEE OR MEMBER

1. Date when your health first began to be affected	Month Day Year	On what date did you become totally disabled so as to be prevented from doing any work?	Month Day Year
2. Describe fully the nature of your disability and its cause			
3. Are you now totally disabled and unable to work?	<input type="checkbox"/> Yes <input type="checkbox"/> No	State briefly your present daily activities	
4. What physicians have you consulted during your present disability?			
Name	Address	Phone	Date From To
_____	_____	_____	_____
_____	_____	_____	_____
5. On what date do you expect to be able to return to work?			
Month Day Year			

I hereby authorize any licensed physician, medical practitioner, clinic, hospital, or other medical or medically related facility, insurance company, or other person, organization, or institution, that has any records or knowledge of me to give to Companion Life Insurance Company, or its representative, any such information. A photo copy of this authorization shall be as valid as the original.

Date	Signature of Employee or Member
Signature of Witness	Address
Address	

CLAIMS DIVISION
COMPANION LIFE INSURANCE COMPANY
P.O. BOX 100102
COLUMBIA, SOUTH CAROLINA 29202-3102

WAVIER OF PREMIUM
NOTIFICATION

Group Policy No.	Certificate No.	Name of Employee
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CHECK LIST FOR GROUP POLICYHOLDER

PLEASE HAVE THE EMPLOYEE COMPLETE THE ATTACHED CLAIM FORMS ONLY IF
THE ANSWERS TO QUESTION 1, 2, AND 3, BELOW, ARE "YES"

- | | Yes | No |
|---|--------------------------|--------------------------|
| 1. Is Employee's insurance in force (or has he been terminated for less than one year)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Has Employee been continuously totally disabled for twelve months or longer? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Was Employee less than 60 years old when he became disabled? | <input type="checkbox"/> | <input type="checkbox"/> |

IF THE EMPLOYEE IS DETERMINED TO BE ELIGIBLE FOR THE WAIVER OR PREMIUM BENEFIT, COMPLETE THIS FORM AND RETURN TO COMPANION LIFE IMMEDIATELY AFTER THE ATTACHED CLAIM FORMS ARE RELEASED TO THE EMPLOYEE FOR COMPLETION.

NOTE: Please send the individual enrollment application to Companion Life with this notice if your group plan is self administered.

DATE

SIGNATURE OF GROUP PLAN ADMINISTRATOR

TO: Companion Life
P.O. Box 100102
Columbia, SC 29202-3102

RE: Waiver of Premium

I, _____, do hereby certify that
I am not engaged in any business or occupation or performing any work of whatever kind or nature for
compensation or profit.

Signature

Date