Companion Life

Companion Life Insurance Company

ATTENDING PHYSICIAN'S STATEMENT

PROOF OF TOTAL DISABILITY

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.

Return To: Companion Life P.O. Box 1535, Dubuque, IA 52004-1535

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 (Sight Limitation) ❑
(American Heart Association) Class 3 (Marked limitation) ❑ Class 4 (Complete Limitation) ❑
(b) Blood Pressure (last visit) . . . . . _____

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 ___/___/___ (Mo. Day Yr.) 1 Mo. ❑ 1-3 Mos. ❑ 3-6 Mos. ❑ Never ❑

(b) ANY OTHER TYPE OF WORK ___/___/___ (Mo. Day Yr.) 1 Mo. ❑ 1-3 Mos. ❑ 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 ❑

		PATIENT'S JOB.		ANY OTHER WORK
(c) When could trial employment commence.....	___/___/___ (Mo. Day Yr.)	Full-time ❑ . .	___/___/___ (Mo. Day Yr.)	Full-time ❑
		Part-time ❑ . .		Part-time ❑

(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 | Zip Code

Signature | Date