# ASSOCIATION
# GROUP LIFE - Waiver of Premium / Permanent Total Disability (PTD) / Disability Extension Claim Form

THE HARTFORD

**INSTRUCTION PAGE**
Claim form for Group Life Insurance Waiver of Premium for covered insureds who have become disabled and unable to work.

**Why apply for Group Life Waiver of Premium?**
If a covered insured becomes disabled as defined by their Group Life plan, the Waiver of Premium benefit, featured on many of The Hartford's Group Life Insurance policies, offers a safeguard against losing valuable Group Life coverage. For insureds who apply and are approved, no Group Life premiums are due after the Waiver of Premium waiting period has been satisfied, and coverage continues in accordance with the policy provisions.

**** Note: Group Life premiums are due and payable during the Waiver of Premium waiting period unless the insured has already converted coverage to an individual policy.**

## ADMINISTRATOR'S RESPONSIBILITY - SECTION 1

1. Detach and complete the Administrator Section, sign and date. Without this information, the claim cannot continue.
2. If any portion of the Group Life coverage was elected, please attach a copy of the enrollment history for all benefit elections.
3. Attach a copy of the most recent Beneficiary Designation Form.
4. Give the remaining sections of the form, including the instruction sheet, to your insured. Ask him/her to complete the Insured Sections and return the claim form to you. (Your insured should detach the *Attending Physician's Statement - Initial Report* [Attending Physician Statement], pages 1 and 2, and forward to his/her phusician for completion).
5. SUBMIT THE ADMINISTRATOR'S STATEMENT AND ATTACHMENTS DIRECTLY TO THE HARTFORD BEFORE THE CLAIM SUBMISSION PERIOD* SPECIFIED UNDER THE POLICY.

**** Please verify if the insured qualifies for any other group benefits through The Hartford and submit a claim accordingly.**

## INSURED'S RESPONSIBILITY - SECTION 2

1. Fully complete Insured Section - pages 1 and 2.
2. Read, sign and date Important Notice and Claim Certification, Insured Section - page 3.
3. Read, complete, sign and date the Authorization at the bottom, Insured Section 2 - page 5.
4. Remove the Attending Physician's Statement - Initial Report - pages 1 and 2; and:
   a) Complete the Insured information at the top of the Attending Physician's Statement - Initial Report.
   b) Provide the Attending Physician's Statement - Initial Report, to the physician certifying your disability. Ask your physician to complete the form and return it within 10 days to The Hartford. Be advised that you are responsible for any fees charged by your physician for completion of this form.
5. TO QUALIFY FOR BENEFITS SUBMIT THE FOLLOWING BEFORE THE SUBMISSION PERIOD* SPECIFIED UNDER YOUR GROUP PLAN:
   a) Completed Insured Sections and all attachments. Make a copy to keep with your records;
   b) The Attending Physician's Statement - Initial Report, which should be sent separately by your physician;
   c) The Administrator section, which should be sent separately.
6. Please follow up to make sure that this claim form, all attachments, and the *Attending Physician's Statement - Initial Report*, are received by The Hartford within the submission period* specified under your Group Life plan.

**SEND THE CLAIM FORM TO:**

For questions about how to complete this form call The Hartford Toll-free at:
**1-888-563-1124**

**** Please review your plan certificate to verify the submission period applicable to you.**

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THE HARTFORD

**ADMINISTRATOR SECTION 1**

**This is a time-sensitive document**

***Please review the plan certificate to verify the submission period applicable**

## A. STATEMENT OF ADMINISTRATOR (Please attach Certificate of Benefit Schedule if possible)

| | | |
|---|---|---|
| Name of Association/Affinity Group: | Plan of Insurance: | Policy Number: |
| Name of Insured: | | Social Security Number of Insured |
| Address of Insured: (Street, City, State & Zip Code) | | Date of birth of insured: (mm/dd/yy) / / |
| Date of Loss: (mm/dd/yy) / / | Effective Date of Insured's Original Insurance: (mm/dd/yy) / / | Effective date of Insured's Insurance Increase, if applicable: (mm/dd/yy) / / |
| Amount of Increase: | Amount of Insurance in Force at Disability: | Insured paid to date: (mm/dd/yy) / / |
| If claim is being filed for an eligible dependent, give dependent's insurance effective date: / / | | |
| Date of Birth of Dependent: / / | Relationship: | Optional Rider(s), Amount(s) and effective date(s) if applicable. Please attach Policy Schedule when possible. Amount of Rider $ Effective Date: / / |

Date: _____ Signed for Administrator by: _____

## B. INFORMATION ABOUT THE DISABILITY

Before the insured became totally disabled, were any changes made to the insured's job responsibilities because of the disabling condition? ☐ Yes ☐ No. If "Yes," what were the changes and when were they made? _____

What was the insured's permanent job or occupation title on his or her last day at work? _____

| | |
|---|---|
| How long had the insured been in this job? _____ | Full time? ☐ Yes ☐ No |
| Date insured is expected to, or did return to work: _____ | Why did insured stop working? _____ |

Is the cause of insured's condition work related? ☐ Yes ☐ No

Is your insured receiving income from other sources? e.g.: ☐ Short Term Disability ☐ Long Term Disability

☐ Workers' Compensation ☐ Social Security **(If applicable, provide name and address of insurance carrier)**

## C. REQUIRED ATTACHMENTS AND SIGNATURE

**For Voluntary Group Life Insurance coverage, attach a copy of the enrollment form history, and/or copies of the Electronic Benefits (screen prints).** I hereby certify that the information provided in the Administrator's Section is true and complete to the records of the Administrator, I agree that this information is subject to audit by Hartford Fire Insurance Company, Hartford Life Insurance Company or Hartford Life and Accident Insurance Company and/or its representatives.

_____ _____

Name *(Please print or type)* Title

_____ _____ ( )

*Signature of Administrator Representative* Date Telephone Number

# ASSOCIATION
# GROUP LIFE - Waiver of Premium / Permanent Total Disability (PTD) / Disability Extension Claim Form

**INSURED SECTION 2**

**This is a time-sensitive document**

***Please review your plan certificate to verify the submission period applicable to you.**

**Group Policy Number:** _____

**Insured Name:** _____

**Be sure to answer all questions - missing information may delay your claim.**

## A. INFORMATION ABOUT YOU

Name: ☐ Male ☐ Female

Address:

Personal Cell Phone Number: (  ) _____ Alternate Telephone Number: (  ) _____ E-Mail address: _____

May we have your authorization to leave confidential medical and benefit information on your personal cell phone? ☐ Yes ☐ No

Signature: _____ Date: _____

If your Policy contains a Permanent and Total Disability provision and you are eligible and would like to apply, please complete below:

Amount of Permanent Total Disability (PTD) requested*: $ _____

*__Note__: The amount requested may not exceed the percentage of the Employee/Insured's Life Insurance Amount set forth in the policy and is subject to the minimum and maximum amounts contained in the Policy. **As a result of electing the Permanent Total Disability benefit, the total face amount of your group life insurance coverage will be reduced by the amount of the Permanent Total Disability benefit.**

At the time of your TOTAL disability began, were you working more than one job (including self-employment)? ☐ Yes ☐ No

If "Yes". provide the name, address and phone number of other employers and indicate when you worked (or were self-employed).

Please indicate your educational history: (Check or Circle last year completed.)

Education through High School 1 2 3 4

College 1 2 3 4 ☐ Masters ☐ Ph.D.

Are you now attending school? ☐ Yes ☐ No

Trade or technical school: (Describe course of study.)

_____

_____

_____

Describe your last four jobs. (Begin with your most recent job.)

| | Company | Job Title | Duties | Years |
|---|---|---|---|---|
| (a) | | | | |
| (b) | | | | |
| (c) | | | | |
| (d) | | | | |

Are you receiving any income from other sources?

| | Amount | Name | Address | Phone |
|---|---|---|---|---|
| Short Term / Long Term Disability | $ | | | (  ) |
| Workers' Compensation | $ | | | (  ) |
| Individual Disability | $ | | | (  ) |
| Self-employment or Part-time work | $ | | | (  ) |

## B. INFORMATION ABOUT THE CONDITION CAUSING YOUR DISABILITY

Describe your medical condition: _____

Why did you stop working? _____

If caused by an illness, have you had this illness before? ☐ Yes ☐ No If "Yes," when? _____

If caused by an injury, when, where and how did the injury occur? _____

Date you were first treated by a Medical Provider for the disabling illness or injury: _____

Name of Medical Provider

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 the cause of your condition related to your job? ☐ Yes ☐ No If "Yes," explain: _____

What important duties of your job are you unable to perform? _____

Are you now engaged in the duties of any occupation or endeavor for wages, profit, compensation or volunteerism? ☐ Yes ☐ No

## C. INFORMATION ABOUT YOUR DISABILITY

Last day you physically reported to work: _____ Since that date, have you done any work? ☐ Yes ☐ No
If "Yes," please indicate dates worked, name and address of employer and amount earned.

Have you returned to work in any capacity? ☐ Yes ☐ No If you have not returned to work, do you expect to? ☐ Yes ☐ No

If "Yes," part-time *(date)* _____ full-time *(date)* _____

## D. INFORMATION ABOUT YOUR PHYSICIANS

List all physicians you have seen for this condition *(attach a separate sheet if needed)*

Doctor's Name | Specialty | Dates seen

Address

City/State/Zip Code | ( ) Telephone Number | ( ) FAX Number

Doctor's Name | Specialty | Dates seen

Address

City, State, Zip Code | ( ) Telephone Number | ( ) FAX Number

Doctor's Name | Specialty | Dates seen

Address

City, State, Zip Code | ( ) Telephone Number | ( ) FAX Number

**E. Important Notice - Please read the statement that applies to your state of residence and sign the bottom of the page.**

**For residents of all states EXCEPT Arizona, Alabama, California, Colorado, Florida, Kentucky, Maine, Maryland, New Jersey, New York, Ohio, Oklahoma, Oregon, Pennsylvania, Puerto Rico, Tennessee, Virginia and Washington:** 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.

**For Residents of 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.

**For Residents of Alabama:** 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.

**For Residents of California:** For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**For residents of Colorado:** 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 award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

**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 Kentucky:** Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim or an application for insurance 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.

**For residents of Maine, Tennessee, and Washington:** 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 and denial of insurance benefits.

**For Residents of Maryland:** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit and 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.

**For residents of New Jersey:** 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 insurance policy is subject to criminal and civil penalties.

**For residents of Ohio:** Any person who, with intent to defraud or knowing 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.

**For residents of Oklahoma:** 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.

**For residents of Oregon:** 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 that the insurer relied upon is subject to a denial and/or reduction in insurance benefits and may be subject to any civil penalties available.

**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 of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material hereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**For residents of Puerto Rico:** Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

**For residents of Virginia:** Any person who, with the 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 the state law.

**For residents of 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.

The statements contained in this form are true and complete to the best of my knowledge and belief.

Signature _____ Date _____

# AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I allow all doctors, hospitals, other health care providers, pharmacy, pharmacy benefit managers, government agencies (including, but not limited to, Federal, State or Local, and the Social Security Administration and Veterans Administration), insurers, employers, financial institutions, educational institutions, health plans, health insurance carriers, policyholders, contract holders, vendors, health and benefit insurers and administrators or their successors ("Records Holders") to give to and discuss with The Hartford and its representatives, the following personal, private, or privileged information, records, or documents related to:

| Insured's Name (Please Print) | Date of Birth | Employer/Policyholder's Name: |
|---|---|---|
| | | |

Any and all medical information or records, including medical histories, physical, mental, or diagnostic examinations, pharmaceutical records, and treatment notes, and including information regarding HIV/AIDS, communicable diseases, alcohol or substance abuse, and behavioral or mental health (but excluding psychotherapy notes); work and performance information and history, including job duties and earnings; information on any insurance coverage and claims filed, including all records and information related to such coverage and claims; financial information, including pension benefits and bank records; business transaction billing and payment records; academic transcripts; and any and all information concerning Social Security or other government benefits, including monthly benefit amounts, monthly payment amounts, entitlement dates, and information from my Master Beneficiary Record. The information obtained by use of this Authorization will be used by The Hartford (including subsidiaries and affiliates) for the purpose of evaluating and administering my claim(s) for benefits and /or leave request(s) and/or request(s) for accommodation. Such information shall be referred to herein collectively as “My Information.”

I understand that once My Information has been disclosed to The Hartford as permitted under this Authorization, it may be re-disclosed by The Hartford as permitted by law or my further authorization. Without limiting the foregoing, I authorize The Hartford to use or disclose My Information (i) to my employer for: a) functions related to accommodating my restrictions/limitations, including in accordance with law; b) responding to claims related to accommodation, adverse or discriminatory treatment related to my claim or condition; c) responding to complaints by me or my representative relating to benefits, leave or accommodation; d) responding to any litigation, agency or regulatory proceeding, grievance, alternative dispute resolution, or lawful subpoena (including regarding employment claims); e) federal, state, or other leave administration; f) fulfilling fiduciary obligations under my benefit plan; or (g) claim, other audits or benefit program reviews; (ii) to administrators or other service providers, including health and wellness vendors, of my employer’s benefit plan(s) and/or programs, including leave management, for plan, benefit, or program related functions or data aggregation and analysis; (iii) to any electronic claim systems or programs or third party vendors used for claims administration or processing or to any insurance broker to carry out functions related to my benefit plan/program or claim; (iv) to any health care professional who has treated or evaluated me or who may do so; (v) to other persons or entities performing business, medical, or legal services related to my claim; (vi) for other insurance, reinsurance or analytical purposes, including workers’ compensation insurance, Social Security Disability insurance, or subrogation or reimbursement purposes ; (vii) as may be lawfully required; (viii) as may be reasonably necessary to protect the personal safety of others or myself; (ix) as may be reasonably necessary to respond to regulatory or similar complaints; and (x) as may be reasonably necessary to prevent or detect perpetration of a fraud. I understand that My Information disclosed to The Hartford and re-disclosed to others could include information regarding alcohol and substance abuse, HIV/AIDS, other communicable diseases, and behavioral and mental health records.



***(Continue to next page)***



LC-3763-25 12/2022
LC-7708-3 12/2022

I understand that once my Information is given out as allowed in this form, federal privacy laws may not protect it and it may be re-disclosed by The Hartford. I also understand that information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient. The Authorizations set forth herein expire two years from the date listed below, or upon my written revocation, if earlier, except as may be reasonably necessary to prevent or detect perpetration of a fraud, adjudicate a benefits claim, respond to regulatory or similar complaints, or protect the personal safety of others or myself. I understand that if The Hartford is the administrator of my employer's self-insured disability program or leave program that my employer is entitled to receive my records without this Authorization. I understand that a revocation of this Authorization is not effective to the extent that any of my Record Holders or The Hartford has relied on this Authorization or to the extent that the Hartford has a legal right to contest a claim for benefits or to contest the policy. If I do not sign this Authorization, The Hartford may not be able to review my claim and determine whether I am eligible for benefits. This may result in a delay or denial of my request for benefits.

The Information released under this Authorization can be submitted to The Hartford electronically, by phone or fax, or by mail. I agree that a copy of this Authorization may be treated as a signed original. I understand that I am entitled to receive a copy of this Authorization upon request. If there is a conflict between a prior request for restriction on the disclosure of My Information and this Authorization, this Authorization will control.

**NOTICE TO INFORMATION PROVIDERS:**
The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family members genetic tests, the fact that an individual or an individuals' family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. Please note that it is appropriate under GINA to provide family medical history when an employee is requesting leave to care for a family member.

_____ _____

**Signature of Claimant or Legal Representative** **Date**

_____

**Name and Relationship to Claimant** *(if signed by Legal Representative)*

**Form must be signed and dated.**

Please fax the completed form to:
Fax Number: 866-954-2621
The Hartford
P.O. Box 14299
Lexington, KY 40512-4299

Clear Form

# Attending Physician's Statement – Initial

**The patient is responsible for completion of this form without expense to the company**

| Patient Last Name: | Patient First (or Preferred) Name: | Date of Birth: | Claim Id Number: |
|---|---|---|---|

## Condition

Patient's condition is a result of:
☐ Illness ☐ Injury
☐ Pregnancy

If illness or injury, is condition related to:
☐ Work Activity
☐ Motor Vehicle Accident
☐ Intentional/Self-Inflicted

If pregnancy, what is date of delivery?
__/__/____ (MM DD YYYY) ☐ Actual ☐ Estimated

Condition onset:
__/__/____ (MM DD YYYY)

First day recommended out of work:
__/__/____ (MM DD YYYY)

Projected return to work date:
__/__/____ (MM DD YYYY)

Office visit to complete this form:
__/__/____ (MM DD YYYY) ☐ In Person ☐ Telemedicine

## Disabling Diagnosis(es) and Impact to Function

ICD 10 Codes
Please provide most specific codes:
|__||__||__|.|__||__||__||__| \ |__||__||__|.|__||__||__||__|

Description of corresponding symptoms
_____
_____

## Co-Morbid Conditions with Impact to Diagnosis

☐ None ☐ Opioid Usage ☐ Psoriasis ☐ Mental Health
☐ Diabetes ☐ Heart Disease ☐ Asthma/Bronchitis ☐ Cognitive Impairment
☐ Hypertension ☐ Obesity ☐ Auto-Immune Disease
☐ COPD ☐ Arthritis ☐ Other _____

In your opinion is the patient competent to endorse checks and direct the use of proceeds? ☐ Yes ☐ No

## Treatment Plan

☐ Conservative treatment ☐ Bed Rest ☐ Palliative care ☐ Hospice Care

☐ Hospitalization Admittance date: __/__/____ (MM DD YYYY) Discharge date: __/__/____ (MM DD YYYY)

☐ Next/Another appointment Date: __/__/____ (MM DD YYYY) ☐ In Person ☐ Telemedicine

☐ Physical/Occupational therapy |__| times per week ☐ until __/__/____ (MM DD YYYY) ☐ Actual ☐ Estimated

☐ Surgery Date: __/__/____ (MM DD YYYY) CPT Code(s): |__||__||__||__||__| \ |__||__||__||__||__|

☐ Referral to a specialist Type: _____ Contact Info:_____

## Current Medications (related to condition or impacting function)

☐ None ☐ Over counter medications: _____

☐ Prescription medications Name(s): _____

☐ Impacting function? ☐ Yes ☐ No If yes, why? _____

☐ Chemotherapy ☐ Radiation Start Date: __/__/____ (MM DD YYYY) End Date: __/__/____ (MM DD YYYY)

**Please fax the completed form to:**
**Fax Number: 866-954-2621**
**The Hartford**
**P.O. Box 14299**
**Lexington, KY 40512-4299**

# Attending Physician's Statement – Initial

**The patient is responsible for completion of this form without expense to the company**

| Patient Last Name: | Patient First (or Preferred) Name: | Date of Birth: | Claim Id Number: |
|---|---|---|---|

**Level of Functionality** (Based upon your medical findings and opinion, address the full range of your patient's abilities. We will conclude that there are no restrictions on function unless specified below.)

Expected duration of any restriction(s) or limitation(s) listed below THROUGH __/__/____
MM DD YYYY

In a workday the patient is able to: (select either Continuous or Intermittent)

| | Continuously with standard breaks | | Intermittently with standard breaks | If intermittent, enter time for each section below | |
|---|---|---|---|---|---|
| | | | | Hours at one time | Total hours in a workday |
| Sit | ☐ | or | ☐ | \|___\| | \|___\| |
| Stand | ☐ | or | ☐ | \|___\| | \|___\| |
| Walk | ☐ | or | ☐ | \|___\| | \|___\| |

**Key: C = Continuously (5.5 – 8 hours) F = Frequently (2.5 – 5.5 hours) O = Occasionally (up to 2.5 hours) N = Never**

| Activity Ability | C | F | O | N | Activity Ability | Right/Left | C | F | O | N |
|---|---|---|---|---|---|---|---|---|---|---|
| ☐ Drive | ☐ | ☐ | ☐ | ☐ | ☐ Squat / Kneel | | ☐ | ☐ | ☐ | ☐ |
| ☐ Weight bearing | ☐ | ☐ | ☐ | ☐ | Hand Dominance | ☐ R ☐ L | | | | |
| ☐ Climb | ☐ | ☐ | ☐ | ☐ | ☐ Fine Manipulation | ☐ R ☐ L | ☐ | ☐ | ☐ | ☐ |
| ☐ Bend | ☐ | ☐ | ☐ | ☐ | ☐ Gross Manipulation | ☐ R ☐ L | ☐ | ☐ | ☐ | ☐ |
| ☐ Max lift | ____LBS | ____LBS | ____LBS | ____LBS | ☐ Reach above shoulder | ☐ R ☐ L | ☐ | ☐ | ☐ | ☐ |
| ☐ Max Carry | ____LBS | ____LBS | ____LBS | ____LBS | ☐ Reach below shoulder | ☐ R ☐ L | ☐ | ☐ | ☐ | ☐ |

**Completed or Planned Diagnostic Tests, Labs and Imaging** (related to the disabling diagnosis)

**Completed:** ☐ X-ray __/__/____ ☐ MRI __/__/____ ☐ CT __/__/____ ☐ EKG __/__/____
MM DD YYYY

☐ ECHO __/__/____ ☐ EMG __/__/____ ☐ Lab Work __/__/____

**Findings of completed tests:** ☐ No significant findings ☐ Confirmed diagnosis

**Planned:** ☐ X-ray ☐ MRI ☐ CT ☐ EKG ☐ ECHO ☐ EMG ☐ Lab Work Scheduled date __/__/____
MM DD YYYY

**Provider Details**

Provider Name: _____
Specialty: _____
EIN Number: _____
License Number: _____

Email: _____
Phone: (___) ___-____
Fax: (___) ___-____

Provider Signature: _____

Date: __/__/____
MM DD YYYY