HARTFORD LIFE INSURANCE COMPANY
HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY
ATTENDING PHYSICIAN'S STATEMENT OF DISABILITY

Clear Form

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 named physician for the purpose of claim processing.

SIgned *(Patient)* _____ 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: _____

_____ Specialty: _____

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

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: _____