

Claim Forms and Instructions for Group Long Term Disability

EMPLOYER

EMPLOYER – Form Completion Information:

NOTICE OF CLAIM – Instructions

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Approximately 45 days prior to the end of elimination period:

1. **COMPLETE** (Pages 2 – 5)
 - Employer's Report of Claim
 - Physical Demands Analysis and Job Functions Summary
2. **INCLUDE:**
 - Job Description (detailed duties)
 - Copy of enrollment card (if employee contributes to premium)
 - Copy of approved medical evidence of insurability if required at time of enrollment
 - Documentation of earnings
 - If Workers' Compensation claim filed, include copy of First Report of Accident and the decision
 - Life Insurance Enrollment Form if self Billed and covered under a UnitedHealthcare Specialty Benefits Group Life Insurance Policy.
3. **TRANSMIT** completed forms and attachments to:
UNITEDHEALTHCARE SPECIALTY BENEFITS
PO Box 7466
Portland, ME 04112-7466
Tel 888 299 2070 Fax 888 505 8550
4. **PROVIDE** employee with the accompanying Claim Forms (Pages 6 – 11)
 - Group Long Term Disability Claim Instructions
 - Employee's Disability Benefit Application
 - Employee's Disclosure Authorization
 - Employee's Authorization of Personal Representative
 - Attending Physician's Statement - If there is more than one treating physician, an additional claim form should be provided for each.
5. **REQUEST:**
 - Copy of awards from other source of benefits: Social Security, Workers' Compensation, Retirement, State Disability, others

**ALL PORTIONS OF THIS CLAIM FORM PACKAGE MUST BE COMPLETED TO AVOID UNDUE
DELAY IN PROCESSING EMPLOYEE'S REQUEST FOR BENEFITS**

EMPLOYER'S REPORT OF A CLAIM

TO BE COMPLETED BY EMPLOYER

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1. Employee's Full Name (Last, First, Middle Initial)		2. Social Security Number	3. Date of Birth
4. Address		City	State Zip Code
5. Insurance Class	6. Employee Date of Hire	7. Date employee became insured for LTD <small>*Attach E of I if required</small>	8. Date employee was actually last present at work
9. Occupation at time last worked (Attach job description)		10. Work schedule at time last worked No. of days per week _____ No. of hours per day _____	
11. Were there any changes to the employee's job responsibilities due to the disabling condition before the employee became fully disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No		12. If yes, what were the changes and when were they made?	
13. Reason for stopping work: <input type="checkbox"/> Sickiness <input type="checkbox"/> Granted LOA <input type="checkbox"/> Laid Off <input type="checkbox"/> Retired <input type="checkbox"/> Dismissed <input type="checkbox"/> Other: <input type="checkbox"/> Resigned <input type="checkbox"/> Vacation		14. Has employee returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, <input type="checkbox"/> Part-time Date: _____ <input type="checkbox"/> Full-time Date: _____	
15. How is employee paid? <input type="checkbox"/> Straight Salary <input type="checkbox"/> Hourly \$ _____ <input type="checkbox"/> Salary & Commissions* <input type="checkbox"/> Salary & Bonus <input type="checkbox"/> Commission Only * <input type="checkbox"/> Other: <small>*If paid commission, attach breakdown for 12 mos. prior to last day worked</small>		16. Employee's Basic Monthly Earnings (weekly earnings x 52 weeks ÷ 12 mos.) \$ _____ If salary is based on less than 12 months, please indicate number of months _____	
17. Employer Contribution to premium <input type="checkbox"/> Yes <input type="checkbox"/> No * <small>* If EE paid please provide enrollment card</small>	18. If Yes, <input type="checkbox"/> Pre-tax <input type="checkbox"/> Post-tax	19. If Post-tax*: _____ % paid by employer _____ % paid by employee <small>*If this section is blank, we will assume it is 100% employer contributions and calculate FICA taxes accordingly.</small>	
20. Has insured received other disability payments since time last worked? Salary Continuance: <input type="checkbox"/> Yes: Weekly Amount \$ _____ Date benefits cease: <input type="checkbox"/> No Insured Short Term: <input type="checkbox"/> Yes: Weekly Amount \$ _____ Date benefits cease: <input type="checkbox"/> No Other Type: <input type="checkbox"/> Yes: Weekly Amount \$ _____ Date benefits cease: <input type="checkbox"/> No			
21. Did Claim result from job activity? <input type="checkbox"/> Yes (Explain) <input type="checkbox"/> No	22. Has a Worker's Compensation claim been filed? <input type="checkbox"/> No <input type="checkbox"/> Yes (Enc. copy of 1 st Report of accident) <input type="checkbox"/> Pending <input type="checkbox"/> Denied (Enc. copy)	23. Weekly Amount \$ _____ 24. Workers' Compensation Carrier, Address, Phone No _____	
25. Is employee or will employee be eligible for a disability or retirement pension? <input type="checkbox"/> Yes* <input type="checkbox"/> No <small>Note*: If any portion of this pension benefit is attributable to the employee's contribution, please provide details including the percentage of his/her contribution to the total contribution.</small>	26. Type*: <input type="checkbox"/> Disability Date Eligible Mo. Amount: \$ _____ <input type="checkbox"/> Retirement Date Eligible Mo. Amount: \$ _____ <input type="checkbox"/> 401(k) Date Eligible Mo. Amount: \$ _____ <input type="checkbox"/> Other Date Eligible Mo. Amount: \$ _____ <small>*Please include a copy of the summary plan description</small>		
27. Does your company have a rehire or return-to-work policy for disabled employees? <input type="checkbox"/> Yes <input type="checkbox"/> No	28. If Yes, please describe: _____		
29. What is the name and title of the manager we should contact if we identify a rehabilitation or return-to-work option? _____ Name Title Telephone Number (include area code)			
30. Is this employee also covered under a UnitedHealthcare Group Life Insurance Policy? <input type="checkbox"/> Yes* <input type="checkbox"/> No <small>*If yes, please provide:</small> Life Group No: _____ Basic Benefit Amount \$ _____ Supplemental Benefit Amount: \$ _____ If Self Billed, please provide a copy of the Life Enrollment Form			
Employer's Name (name of policyholder, if other)		Telephone Number (include area code)	Group Policy No
Address		Employer (Taxpayer) I.D. No. (EIN)	Public Employer SS No. 69
Name of person completing this form (please type or print)			Title
Signature of person completing this form			Date

Please attach Job Description and submit with completed Physical Demands Analysis and Job Function Summary

PO Box 7466 Portland ME 04112-7466 Tel 888 299 2070 Fax 888 505 8550

JOB FUNCTIONS SUMMARY

(Continued)

TO BE COMPLETED BY EMPLOYER

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PUSHING/PULLING EXPLANATION

Dynamic Pushing/Pulling (pushing/pulling an object and walking/moving with it)

Object/task description	Force to start push (force to get object moving)	Force to maintain push (force to keep object moving)	Distance (How far)	Frequency (How often)

OTHER PHYSICAL DEMANDS	Not Present <33% 33 - 66% >100%				WORK CONDITIONS	Not Present <33% 33 - 66% >100%			
	Not Present	<33%	33 - 66%	>100%		Not Present	<33%	33 - 66%	>100%
Climbing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heat	<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"/>	Cold	<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"/>	Wet/Humid	<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"/>	Fumes/Dust/Dirt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Handling:					Confined Areas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1 hand control	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Places	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2 hand control	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Equipment in Motion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grasping:					Safety Equip/Clothing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Right hand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Burning Materials	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Left hand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Noise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grasp/turn:					Environmental:				
Right hand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mechanical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Left hand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chemical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Finger dexterity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Electrical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching below shoulders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sharp Tools	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching above shoulders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Slick Floors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching across	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Explosives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching to floor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Radiant Energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Twisting of head	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Material Handling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Twisting of back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Possible Violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Upper extremity ROM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Whole body ROM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Bending at the waist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Operate motor vehicle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
How can this job be modified and for how long?					Setting: Inside _____% Outside _____%				
					Are other jobs available in your company that require <i>similar ability</i> but require <i>less physical effort</i> ?				

Person completing form _____ (_____) _____ Position _____ Phone No. _____ Date _____

Claim Forms and Instructions for Group Long Term Disability

EMPLOYEE

EMPLOYEE – Form Completion Information:

APPLICATION for Group Long Term Disability - Instructions	Page 6 of 13
<ol style="list-style-type: none">COMPLETE <u>Employee's Disability Benefit Application</u> in FULL. (Pages 7 & 8) ATTACH copies of Social Security, Worker's Compensation, Retirement and other income entitlement awards and/or denials (or forward when received).COMPLETE <u>Employee's Disclosure Authorization</u>. (Page 9) This will allow us to secure additional information, if necessary, to make a decision on your claim for benefits. Make a copy to provide to your treating physician(s)COMPLETE <u>Employee's Authorization of Personal Representative</u>. (Page 10) This form is optional and <u>not</u> required to file a claim. If you would like us to discuss your claim with anyone, we require your authorization prior to us releasing any personally identifiable health information.TRANSMIT completed forms and attachments to: UNITEDHEALTHCARE SPECIALTY BENEFITS PO Box 7466 Portland, ME 04112-7466 Tel 888 299 2070 Fax 888 505 8550PROVIDE the <u>Attending Physician's Statement</u> (Page 11) to the physician(s) treating you. If you have more than one physician, you may make copies or obtain additional <u>Attending Physician's Statements</u> from your employer.PROVIDE a copy of your completed <u>Employee's Disclosure Authorization</u> to your physician(s).INSTRUCT your physician(s) to send completed form(s) to: UNITEDHEALTHCARE SPECIALTY BENEFITS PO Box 7466 Portland, ME 04112-7466 Tel 888 299 2070 Fax 888 505 8550	
ALL PORTIONS OF THIS CLAIM FORM PACKAGE MUST BE COMPLETED TO AVOID UNDUE DELAY IN PROCESSING YOUR REQUEST FOR BENEFITS	

EMPLOYEE'S DISABILITY BENEFITS APPLICATION

TO BE COMPLETED BY EMPLOYEE

1. Full Name (Last, First, Middle Initial)		2. Social Security Number		3. Phone Number (include area code)	
4. Address			City	State	Zip Code
5. Date of Birth	6. Height	7. Weight	8. Sex <input type="checkbox"/> M <input type="checkbox"/> F	9. Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Married	10. Is Spouse employed? <input type="checkbox"/> Yes <input type="checkbox"/> No
11. Spouse First and Last Name				12. Spouse Date of Birth	
13. Please list the names and dates of birth of all of your dependents:					
Dependent Name		Date of Birth		Dependent Name	
Date of Birth		Date of Birth		Date of Birth	
14. Employer's Name (include division if applicable)					
15. Occupation (List the duties of your occupation at the time of disability)					
16. Date of accident or date first noticed symptoms of illness		17. Date last worked		18. I returned to work on: <input type="checkbox"/> Part-time <input type="checkbox"/> Full-time	
				19. I expect to return to work on: <input type="checkbox"/> Part-time <input type="checkbox"/> Full-time	
20. Please describe the onset and nature of your illness or injury				21. Have you ever had the same or similar condition in the past? <input type="checkbox"/> Yes: When? _____ <input type="checkbox"/> No	
22. Please describe your typical current daily activities					
23. Are you currently working? <input type="checkbox"/> Yes <input type="checkbox"/> No		24. If Yes, Provide details <input type="checkbox"/> Part-time <input type="checkbox"/> Full-time		25. If No, what about your situation/condition would have to change for you to return to work on a part-time or full-time basis?	
26. Provide the names, address and date you first saw the doctor(s) who are treating you for your disability. If more space is needed, please attach additional paper.					
Physician Name			Phone No. Fax No:		Address
Specialty			Date First Seen		Date Last Seen
					Currently Treating? <input type="checkbox"/> Yes <input type="checkbox"/> No
Physician Name			Phone No. Fax No:		Address
Specialty			Date First Seen		Date Last Seen
					Currently Treating? <input type="checkbox"/> Yes <input type="checkbox"/> No
Physician Name			Phone No. Fax No:		Address
Specialty			Date First Seen		Date Last Seen
					Currently Treating? <input type="checkbox"/> Yes <input type="checkbox"/> No
Physician Name			Phone No. Fax No:		Address
Specialty			Date First Seen		Date Last Seen
					Currently Treating? <input type="checkbox"/> Yes <input type="checkbox"/> No

(Continued on next page)

EMPLOYEE'S DISABILITY BENEFITS APPLICATION

TO BE COMPLETED BY EMPLOYEE

(Continued)

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27. Please list any *restrictions the doctor has placed on your activities: (*restrictions – what your doctor has advised you not to do.)					
28. Please describe any *limitations you have in your activities: (*limitations – what you feel you are unable to do because of your sickness or injury.)					
29. Are you receiving or have you applied for any of the following benefit? (Include benefits for you or any family member)				30. Are you receiving, have you received or have you applied for any type of payment from any employer's retirement member plan? <input type="checkbox"/> Yes* <input type="checkbox"/> No * If YES, complete:	
Type of Benefit	Receiving Payments (Yes/No)	Amount Received	Applied for or appealed No decision	Claim denied no appeal pending.	Name, Address and Telephone Number of Employer:
Social Security Disability					Effective Date:
SS Retirement					Amount of Award: \$
Family/Dependent Social Security Disability					<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Annual
State Retirement					If Lump Sum, Amount: \$
Long Term Disability *					Date Received:
VA Disability					If applied for only, give details:
Workers' Compensation					
Pension Benefits					
* Name, Address, & phone number of insurance company along with claim number of long term disability claim:					
Provide copies of any decisions, including denial and/or award notices for any benefits noted above					
31. If your request for benefits is approved, do you want us to withhold amounts from each benefit check for Federal Income Tax purposes? <input type="checkbox"/> Yes <input type="checkbox"/> No				32. If YES, Amount \$ _____ (Minimum amount per month is \$88.00)	

The above statements are true and complete to the best of my knowledge and belief.

I acknowledge that I have read the applicable Fraud Warning Notices provided with this claim form.

Date: ____/____/____ Signature: _____

Address: _____ Phone (____) _____ - _____

Participant's Name (Please Print): _____

I AUTHORIZE: any doctor, physician, healer, health care practitioner, hospital, clinic, other medical facility, professional, or provider of health care, medically related facility or association, medical examiner, pharmacy, pharmacy benefit manager, employee assistance plan, insurance company, health maintenance organization or similar entity to provide access to or to give UnitedHealthcare Insurance Company (Company) or the Plan Administrator or their employees and authorized agents or authorized representatives, any medical and non-medical information or records that they may have concerning my health condition, or health history, or regarding any advice, care or treatment provided to me. This information and/or records may include, but is not limited to: cause, treatment diagnoses, prognoses, consultations, examinations, tests, prescriptions, or advice regarding my physical or mental condition, or other information concerning me. This may also include, but is not limited to, information concerning: mental illness, psychiatric, drug or alcohol use and any disability, and also HIV related testing, infection, illness, and AIDS (Acquired Immune Deficiency Syndrome), as well as communicable diseases and genetic testing. If my Plan Administrator sponsors both a disability plan underwritten or administered by the Company and a medical plan of any type written by another UnitedHealth Group Company, the information and records described in this form may also be given to any UnitedHealth Group Company which administers such medical or disability benefits for the purpose of evaluating any claim that may be submitted by me or on my behalf for benefits, for evaluating return to employment opportunities, and for administering any feature described in the plan. This information may also be extracted for use in audits or for statistical purposes.

I AUTHORIZE: any financial institution, accountant, tax preparer, insurance company or reinsurer, consumer reporting agency, insurance support organization, Claimant's agent, employer, group policyholder, benefit plan administrator, or governmental agency, including the Social Security Administration, to give the Company or the Plan Administrator or their employees and authorized agents, or authorized representatives, any information or records that they have concerning me, my occupation, my activities, employee/employment records, earnings or finances, applications for insurance coverage, prior claims files and claim history, work history and work related activities.

I UNDERSTAND: the information obtained will be included as part of the proof of claim and will be used to determine eligibility for claim benefits, any amounts payable, return to employment opportunities, and to administer any other feature described in the plan with respect to the Claimant. This authorization shall remain valid and apply to all records, information and events that occur over the duration of the claim, but not to exceed 24 months. A photocopy of this form is as valid as the original and I or my authorized representative may request one. I or my representative may revoke this authorization at any time as it applies to future disclosures, by notifying the Company in writing. The information obtained will not be disclosed to anyone EXCEPT: (a) reinsuring companies; (b) the Medical Information Bureau, Inc., which operates Health Claim Index (HCI); (c) fraud or overinsurance detection bureaus; (d) anyone performing business, medical or legal functions with respect to the claim or the plan, including any entity providing assistance to the Company under its Social Security Assistance Program and employers involved in return to employment discussions; (e) for audit or statistical purposes; (f) as may be required or permitted by law; or (g) as I may further authorize. A valid authorization or court order for information does not waive other privacy rights.

If my medical information contains information regarding drugs or alcohol abuse, I understand that my records may be protected under federal (42 CFR Part 2) and some state laws. To the extent permitted under law, I can ask the party that disclosed information to the Company to permit me to inspect and copy the information it disclosed. I understand that I can refuse to sign this disclosure authorization; however, I understand that if I do so, the Company may deny my claim for benefits pursuant to the plan. The use and further disclosure of information disclosed hereunder may not be subject to the Health Insurance Portability and Accountability Act (HIPAA).

Signature of Claimant or Claimant's Authorized Representative: _____ Date: _____

Relationship, if other than Claimant: _____

RETURN TO:
UnitedHealthcare Specialty Benefits
PO Box 7466 Portland ME 04112-7466
Tel 888 299 2070 Fax 888 505 8550

At my request, and for my convenience, I, _____ hereby authorize **UnitedHealthcare Insurance Company** and any representatives thereof involved in the administration of my disability claim to recognize _____ as my Authorized Personal Representative in relation to such claim.

In connection therewith, I understand that _____ may be given access to information concerning my claim, including personally identifiable health information, and hereby authorize the disclosure of such information to said person when requested or as may be necessary to carry out the purpose of this Authorization. I direct that **UnitedHealthcare Insurance Company** not require any further authentication of the identity of my Authorized Personal Representative beyond the identification of his/her name in writing or orally at the time of any communication.

I further understand that any information provided to my authorized personal representative hereunder may be subject to further disclosure by said person, and I agree to hold **UnitedHealthcare Insurance Company** and its representatives harmless in connection with any such disclosure.

This Authorization shall remain valid so long as my claim shall remain open, but I understand that it may be revoked in writing by me at any time.

Date: ____/____/____

Signature: _____

RETURN TO:

UnitedHealthcare Specialty Benefits
PO Box 7466 Portland ME 04112-7466
Tel 888 299 2070 Fax 888 505 8550

ATTENDING PHYSICIAN'S DISABILITY STATEMENT

TO BE COMPLETED (for employee) BY PHYSICIAN

Legible completion of this form is requested to ensure prompt service to your patient.				
1. Patient Name/Medical Record Number (please print, maiden name if applicable)		2. Date of Birth	Height	Weight
3. When did symptoms first appear or accident happen?	4. Date you advised patient to stop working?	5. Has patient ever had the same or similar condition? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, state when and describe
6. Is condition due to or exacerbated by injury/sickness arising out of patient's employment? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		7. Name & address of other treating physicians		
8. Date of first visit for this illness	9. Date of last visit	10. Diagnosis & ICD10 code (include complications)		
11. Subjective symptoms		12. Objective findings (including current x-rays, EKG's lab and/or clinical findings)		
13. Nature of treatment				
14. If pregnancy, expected delivery date		15. If delivered, actual delivery date		16. <input type="checkbox"/> Vaginal delivery <input type="checkbox"/> C - Section
17. Was patient hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name & address of hospital		Date Admitted	Date Discharged
18. Physical Capacity (Reference: Dictionary of Occupational Titles) <input type="checkbox"/> Very heavy – frequent standing/walking, lift/carry over 100 lbs. <input type="checkbox"/> Heavy - frequent standing/walking, lift/carry up to 100 lbs. <input type="checkbox"/> Medium - frequent standing/walking, lift/carry up to 50 lbs. <input type="checkbox"/> Light - frequent standing/walking, lift/carry up to 20 lbs. <input type="checkbox"/> Sedentary – sitting most of the time, lift/carry up to 10 lbs. <input type="checkbox"/> No work capacity – ADLs (Activities of Daily Living) only.				
19. Mental Capacity (Reference: DSM-IV-TR) <input type="checkbox"/> GAF 61-70 – Some mild symptoms (some difficulty in social, occupational); generally functioning well. <input type="checkbox"/> GAF 51-60 – Moderate symptoms (moderate difficulty in social, occupational); flat affect, occasional panic attacks, conflict with peers. <input type="checkbox"/> GAF 41-50 Serious symptoms (serious impairment in social, occupational); no friends, suicidal, unable to keep job. <input type="checkbox"/> GAF 31-40 Some impairment in reality testing, speech at times illogical, major impairment in several areas. <input type="checkbox"/> GAF < 30 Behavior influenced by delusions and/or hallucinations; acts grossly inappropriate.				
20. Please define "stress" as it applies to this patient		21. What stress and problems in interpersonal relations has patient had on the job?		
22. Additional Remarks				
23. Please describe any *limitations your patient has in his/her activities (*limitations – activities that cannot be performed).				
24. Please list any *restrictions you have placed on your patient's activities (*restrictions – activities that should not be done to prevent progression of disease).				
25. Expected Return to Work Date	26. Can patient resume full duties upon return to work? <input type="checkbox"/> Yes <input type="checkbox"/> No		If no, please explain?	
27. Do you believe the patient is competent to endorse checks and direct the use of the proceeds thereof? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Physician's Name		Degree & Specialty		Tax ID Number
Address			Telephone Number:	
			Fax Number:	
Physician's Signature			Date:	

For claimants in 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 claimants in Alaska:

A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

For claimants in 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 claimants in California:

UnitedHealthcare may terminate your coverage and/or deny any claim under the policy if it is determined that you: knowingly, and with actual intent to deceive, presented false information in this application; and such statement was the basis for UnitedHealthcare's approval of your coverage under the policy.

For claimants in 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 or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

For claimants in Connecticut:

Any person who knowingly presents false information in an application for insurance or life settlement contract is guilty of a crime and may be subject to fines and confinement in prison.

For claimants in Delaware:

Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

For claimants in District of Columbia:

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

For claimants in 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 claimants in Hawaii:

For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

For claimants in Idaho:

Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

For claimants in Indiana:

A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

For claimants in Kansas:

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 may be guilty of fraud as determined by a court of law.

For claimants in Kentucky:

Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

For claimants in Maine:

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 or a denial of insurance benefits.

For claimants in Maryland:

Any person who knowingly or willfully presents a false or fraudulent claim for payment for a loss or benefit or 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 claimants in Minnesota:

A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

For claimants in New Hampshire:

Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

For claimants in New Jersey:

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

For claimants in New Mexico:

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 civil fines and penalties.

For claimants in Ohio:

Any person who, with 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 is guilty of insurance fraud.

For claimants in Oklahoma:

WARNING: Any person who knowingly, and with intent to injure, defraud or deceive and insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

For claimants in Oregon:

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 may be guilty of a crime and may be subject to fines and confinement in prison.

For claimants in 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 thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

For claimants in 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 include imprisonment, fines and denial of insurance benefits.

For claimants in Texas:

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.

For claimants in Vermont:

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing false, incomplete, or misleading information may be guilty of a crime.

For claimants in Virginia:

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 false, incomplete, or misleading information may have violated state law.

For claimants in All Other States:

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.