Aetna™

Disability
Attending Physician's Statement

Complete this form in full.

- The patient is responsible for completion of this form without expense to the company.
- You may use the Remarks section on the reverse side if you need more room to respond.
- If you have any questions, please call **(800) 726-7777**.

Employer Information

Name

Type of Claim
☐ LTD ☐ Waiver of Premium ☐ LTD/PTD

Patient Information

Name | Social Security Number | Birthdate (MM/DD/YYYY)

Address (include No. Street, Town, State, Zip Code) ☐ Address is new

1. History

(a) Height _____ Weight _____

(b) Date symptoms first appeared or accident happened ..... Mo. _____ Day _____ Yr. _____

(c) Date patient ceased work because of disability ..... Mo. _____ Day _____ Yr. _____

(d) Has patient ever had same or similar condition? ☐ No ☐ Yes, state when and describe.

(e) Is condition due to injury or sickness arising out of patient's employment? ☐ No ☐ Yes ☐ Unknown

(f) Names and addresses of other treating physicians

Name _____ Address _____

Name _____ Address _____

Name _____ Address _____

2. Diagnosis

(a) Date of last examination ..... Mo. _____ Day _____ Yr. _____

(b) ICD diagnostic code (**mandatory**)

(c) Diagnosis (including any complications) _____

(d) Subjective symptoms

(e) Objective findings (including **current** X-rays, EKG's, laboratory data and any **clinical findings**):
(1.) **Clinical Findings**:

(2.) **Diagnostic Studies and Results**:

(f) If disability is due to pregnancy, the expected delivery date is ..... Mo. _____ Day _____ Yr. _____

(g) Other disease or infirmity affecting present condition _____

3. Dates of Treatment

(a) Date of first visit ..... Mo. _____ Day _____ Yr. _____

(b) Date of last visit ..... Mo. _____ Day _____ Yr. _____

(c) Frequency ..... ☐ Weekly ☐ Monthly ☐ Other (specify) _____

(d) Is patient still under your care for this condition?
☐ Yes ☐ No, indicate date service terminated. _____

4. Nature of Treatment

(a) Type and dates of treatment:

(b) Prescribed medications:

(c) Surgical procedures and dates:

5. Progress

(a) Patient has ..... ☐ Recovered ☐ Improved ☐ Stabilized ☐ Retrogressed

(b) Patient is ..... ☐ Ambulatory ☐ House confined ☐ Bed confined ☐ Hospital confined

(c) Has patient been hospital confined?
☐ No ☐ Yes, give name and address of hospital _____

Confined from _____ through _____

01-001

6. Cardiac (if applicable)

(a) Functional capacity limitation (American Heart Ass'n): ☐ Class 1 (none) ☐ Class 2 (slight) ☐ Class 3 (marked) ☐ Class 4 (complete)

(b) Blood Pressure (last visit): _____ / _____ Systolic / Diastolic

7. Limitations

(a) What are patient's present capabilities?

(b) What are present limitations (physical and/or mental)?

(c) What restrictions are placed on patient?

8. 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:

9. Mental/ Nervous Impairment (if applicable)

Please define "stress" as it applies to this claimant.

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

10. Prognosis

(a) What is the patient's prognosis?
☐ Guarded ☐ Good ☐ Fair ☐ Poor ☐ Other

(b) When do you feel patient's maximum medical improvement will be reached?
☐ 1 Mo. ☐ 1-3 Mos. ☐ 3-6 Mos. ☐ 6-9 Mos. ☐ 1 yr. or longer

(c) What is the estimated date of the patient's return to work?
☐ own job/occ _____ ☐ other occ _____ ☐ no return expected

(d) Do you consider the patient to be a viable candidate for **Vocational Rehabilitation** (job retraining)?
☐ Yes ☐ No, please explain

Remarks

Attending Physician's Name (print)	Specialty	Degree

Address (No. Street, City, State, Zip Code)	Telephone

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 claim was provided by the applicant.

California Residents: For your protection, California law requires notice of the following: Any person who knowingly and with intent to defraud or deceive any insurance company files a statement of claim containing any materially false, incomplete or misleading information is guilty of a crime and may be subject to fines, confinement in a state prison and substantial civil penalties.

Colorado Residents: An insurer or agent who knowingly provides false or misleading information to defraud a claimant regarding insurance proceeds must be reported to the Insurance Division.

Pennsylvania Residents: 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.

Signature	Date