Participant Accident Statement of Claim for Disabilty Benefits

Connecticut Interlocal Risk Management Agency (CIRMA)

IMPORTANT INSTRUCTIONS FOR COMPLETING CLAIM FORM(S)

To the Policyholder and Claimant:

We know this is a difficult time, and we want to assist you in filing your claim as quickly as possible. Please read these important instructions regarding completion of these forms.

The information below constitutes a complete claim filed with The Hartford for purposes of claiming Participant Accident Disability benefits.

Part I – Policyholder's Statement

- ☐ Form is to be completed in its entirety and signed by the Official Representative of the Policyholder/Plan.
- ☐ Provide any necessary attachments (see Section D).

Part II – Employer's Statement

- ☐ Form is to be completed in its entirety and signed by the Official Representative of the Insured's Employer.
- ☐ Provide any necessary attachments (see Section G).

Part III – Claimant's Statement

- ☐ Form is to be completed in its entirety and signed by the insured who is claiming Disability benefits.
- ☐ Sign the Authorization to Obtain and Disclose Information, page 9.
- ☐ Provide a copy of the insured's driver's license.

Part IV – Attending Physician's Statement

- ☐ Form is to be completed in its entirety and signed by the healthcare provider who is treating the Claimant.
- ☐ Sign and date the form on page 10.
- ☐ Provide office visit notes, test results, etc. for the period the Claimant has been treated for the disabling condition.

Submit claim by mail to: Connecticut Interlocal Risk Management Agency (CIRMA)
545 Long Wharf Drive, 8th Floor,
New Haven, CT 06511
Telephone: 1-800-526-1647
Email Address: wc_fax@ccm-ct.org

Release of claim forms is not an admission of coverage under a policy for a policyholder, group, or organization.

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

PLEASE SEE THAT ALL SECTIONS ARE FULLY COMPLETED AND SIGNED.

Clear Form

Participant Accident
Statement of Claim for Disability Benefits

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PART I - POLICYHOLDER'S STATEMENT - To be completed by the Official Representative of the Policyholder/Plan

A. Information About the Policyholder

Policy Number:	Policyholder Name:		
10 VP 850031	Connecticut Interlocal Risk Management Agency (CIRMA)		
Policyholder Email Address:		Policyholder Telephone Number: ( )	Policyholder Fax Number: ( )
Policyholder Address (Street, City, State, & Zip Code): 545 Long Wharf Drive, 8th Floor, New Haven, CT 06511			
Participating Organization (or "n/a" if this does not apply):	Class (or "n/a" if this does not apply):		

B. Information About the Claimant

Claimant Name:	Claimant DOB:	Claimant Social Security Number:
Claimant Address (Street, City, State, & Zip Code):		Claimant Telephone Number: ( )

C. Information About the Claim

Benefits claimed for Disability due to:
☐ Accidental Injury ☐ Contagious and Infectious Disease ☐ Influenza ☐ Heart or Circulatory Malfunction

Nature of injury(ies) (if applicable):	Nature of sickness (if applicable):	
Date of Accident/Onset:	Time of Accident/Onset (hh:mm): ☐ AM ☐ PM	Place of Accident/Onset of Symptoms:
Fully describe the circumstances of the Accident/Onset of Symptoms (Use a separate sheet of paper, if necessary):		

D. Required Attachments and Signature

Please attach copies of the following documents as applicable:
- Medical information from the Claimant's file relating to this disability, if available.
- Incident/police reports relating to the incident.

I hearby certify the Insured is a member of the group insured under the above Policy and the loss was sustained under adequate supervision while participating in an official Covered Activity.

I further certify that the information provided on the Policyholder's Statement is true and complete according to the records of the Policyholder. I agree that this information is subject to audit by Hartford Life Insurance Company, Hartford Life and Accident Insurance Company, Hartford Fire Insurance Company and/or its representative.

Title of Policyholder Official	Signature of Policyholder Official	Date

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PART II - EMPLOYER'S STATEMENT - To be completed by the Official Representative of the Claimant's Employer

A. Information About the Employer

Employer Name:		
Employer Email Address:	Employer Telephone Number: ( )	Employer Fax Number: ( )
Employer Address (Street, City, State, & Zip Code):		
Branch/Location (or "n/a" if this does not apply):	Class (or "n/a" if this does not apply):	

B. Information About the Claimant

Claimant Name:	Claimant DOB:	Claimant Social Security Number:
Claimant Address (Street, City, State, & Zip Code):		Claimant Telephone Number: ( )
Date of Hire:	Occupation/Job Title:	Date Last Worked:

C. Information About the Claimant's Salary

Basic Salary or wage immediately prior to cessation of work because of disability: (exclude bonuses, overtime pay, etc.)
$ ☐ Annually ☐ Monthly ☐ Bi-Weekly ☐ Weekly ☐ Hourly

Is this Claimant receiving salary continuation? ☐ Yes ☐ No If "Yes," what is the weekly amount? $_____ Start Date: End Date:	Is the Claimant receiving Sick Pay? ☐ Yes ☐ No If "Yes," what is the weekly amount? $_____ Start Date: End Date:

D. Information About Other Benefits

Do you have a pension plan? ☐ Yes ☐ No If "Yes," what type? (Check as many as applicable)
☐ Defined contribution ☐ Profit Sharing ☐ 401 K ☐ Other (specify) _____

Is the Claimant eligible for your pension plan? ☐ Yes ☐ No If "No," why?	If eligible, does the Claimant participate? ☐ Yes ☐ No If "No," why?
If the Claimant is participating, when is he or she eligible for benefits under the plan? _____	
At what point does the Claimant qualify for a full pension? _____	Is there a Disability Retirement Option available to this Claimant? ☐ Yes ☐ No
Has a claim been filed with Workers' Compensation? ☐ Yes ☐ No	Name and address of your compensation carrier
Is the Claimant receiving Short/Long Term Disability benefits? ☐ Yes ☐ No If "Yes," weekly amount? $ _____ Start Date: End Date:	Is the Claimant receiving State Disability benefits? ☐ Yes ☐ No If "Yes," weekly amount? $ _____ Start Date: End Date:
List any other sources of income to which the employee is entitled as a result of this disability:	

E. Information About the Physical Aspects of the Claimant's Job

Check the items below that relate to the claimant's job and complete the information requested.
Select either majority of workday or sporadically.

Activity	Majority of workday (with standard breaks)		Sporadically throughout day	If sporadically circle time for each section below: Hours at one time	Total hours/8 hour
Sit	☐	or	☐	1 2 3 4 5 6 7 8	1 2 3 4 5 6 7 8
Stand	☐	or	☐	1 2 3 4 5 6 7 8	1 2 3 4 5 6 7 8
Walk	☐	or	☐	1 2 3 4 5 6 7 8	1 2 3 4 5 6 7 8

Can the job be performed alternating sitting and standing? ☐ Yes ☐ No

Activity	Never	Occasionally (1-33%)	Frequently (34-67%)	Constantly (68-100%)
Driving	☐	☐	☐	☐
Balancing	☐	☐	☐	☐
Bending at Waist	☐	☐	☐	☐
Kneeling/Crouching	☐	☐	☐	☐
Crawling	☐	☐	☐	☐
Climbing	☐	☐	☐	☐

Lift/Carry/Push/Pull: Task Description (Describe object moved and any mechanical assistance in the last column)					
Lifting		lbs.	lbs.	lbs.	
Carrying		lbs.	lbs.	lbs.	
Pushing/Pulling		lbs.	lbs.	lbs.	
Upper Extremity Activity (not load bearing)	**Specify right (R) or left (L) if not bilateral)**				**Describe task performed**
Fine manipulation (fingering, keyboard)	☐	☐	☐	☐	
Gross manipulation (grip/grasp, handle)	☐	☐	☐	☐	
Reach (extend arms) above shoulder	☐	☐	☐	☐	
Reach (extend arms) below shoulder at desk or workbench level	☐	☐	☐	☐	

F. Information About the Job as it Relates to the Disability

Can the job be modified to accommodate the disability either temporarily or permanently? ☐ Yes ☐ No If "Yes," explain:

Is it possible to offer the claimant assistance in doing the job? (e.g., through the use of technology or personal assistance)
☐ Yes ☐ No If "Yes," explain:

Does your company have a rehire or return-to-work policy for disabled employees? ☐ Yes ☐ No

Name, title, and number of the manager we should contact if we identify a rehabilitation or return to work option for the Claimant:

G. Required Attachments and Signature

Please attach copies of the following documents as applicable:

- Job description detailing the essential duties and physical demands of the Claimant's job on the date they last worked
- If salary is based on a W-2, K-1, 1099 or similar document, attach a copy of the document

I certify information provided on the Employer's Statement is true and complete according to the records of the employer.

Title of Policyholder Official	Signature of Policyholder Official	Date

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PART III - CLAIMANT'S STATEMENT - To be completed by the Claimant (BE SURE TO ANSWER ALL QUESTIONS)

A. Information about you

Last Name: First Name: Middle Initial: | Date of Birth: | Social Security Number:

Address: (Street, City, State & Zip Code) | Gender: ☐ Male ☐ Female

Phone Numbers:
Daytime: ( ) Evening: ( ) Personal Cell Phone: ( )
E-mail Address:
May we have your authorization to leave confidential medical and benefit information on your personal cell phone? ☐ Yes ☐ No
and/or request this by E-mail? ☐ Yes ☐ No

Signature Date

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed | Your employer: (include division, if applicable) | Occupation:

Please indicate the extent of your formal education: (Check one)

☐ HS/GED ☐ Trade School/Certification Program ☐ AA/AS ☐ BA/BS ☐ Masters ☐ Doctorate ☐ Some college

☐ Other (please specify):

List all licenses, certifications, majors:

Have you served in the military? ☐ Yes ☐ No

Briefly describe your past work experience for the last 20 years (Begin with your most recent job.)

Dates Employed	Employer	Job Title	Duties

Now, or at some time in the future, would you be interested in seeking rehabilitation to some other kind of work? ☐ Yes ☐ No

Have you contacted your State Department of Vocational Rehabilitation? ☐ Yes ☐ No If "Yes," please include the name, address and telephone number of your counselor.

B. Information About your Family (required to determine your eligibility for Social Security Benefits)

Legal Spouse's Name: (Last, First)

Legal Spouse's Social Security Number: | Date of Birth: (Month/Day/Year) | Is your legal spouse employed? ☐ Yes ☐ No | Retired? ☐ Yes ☐ No

Do you have any children under Age 19? ☐ Yes ☐ No If "Yes," please provide the information requested below for each child.

Name: Date of Birth: Social Security Number:
Name: Date of Birth: Social Security Number:
Name: Date of Birth: Social Security Number:

Do you have any children with disabilities (regardless of age)? ☐ Yes ☐ No If "Yes," please provide the information requested below for each child

Name: Date of Birth: Social Security Number:
Name: Date of Birth: Social Security Number:
Name: Date of Birth: Social Security Number:

C. Information About the Condition Causing Your Disability

1. For illness, answer the following questions:

What were your first symptoms?

When did you first notice them?

Have you had this illness before? ☐ Yes ☐ No

If so, when?

2. For an injury, answer the following questions:

When, where and how did the injury occur?

Name and address of law enforcement agency involved and Case Number (if applicable):

3. For illness or injury, answer the following questions:

Next to any Activity of Daily Living (ADL), please place the number shown next to the statement that most accurately reflects your ability/inability to perform each: 1 = I can perform this activity independently; 2 = I can perform this activity with the use of equipment or adaptive devices; 3 = I cannot perform this activity.

( ) Bathe (tub, shower, or sponge)
( ) Dress
( ) Toilet
( ) Transfer from Bed to Chair
( ) Voluntary bladder and bowel control or ability to maintain a reasonable level of personal hygiene.
( ) Feed yourself with food that has been prepared and made available to you.

If you indicated **(3)** for any of the above activities, please describe the impairment and restrictions to your functionality that preclude you from performing this activity.

Height: _____ **Weight:** _____

Have you suffered a severe Cognitive Impairment that renders you unable to perform common tasks, such as using the phone, money management, or medication management? ☐ Yes ☐ No If "Yes," describe:

Date you were first treated by a Healthcare Provider? _____ (Month/Day/Year)

Name of Healthcare Provider:

Address of Healthcare Provider:

What aspect of your condition made you unable to work?

D. Information About the Disability

Last day you worked before the disability: _____ (Month/Day/Year)

Since that date, have you done any work? ☐ Yes ☐ No

If "Yes," please indicate dates worked, name of employer, and amount earned.

Date you were first unable to work: _____ (Month/Day/Year)

If you have not returned to work, do you expect to? ☐ Yes ☐ No

Part time _____ (date)

Full time _____ (date)

E. Information About Healthcare Providers and Hospitals

First medical attention for the current disability was given by (complete below)

Healthcare Provider's Name:

Telephone: ( )
Fax: ( )

Specialty:

Address: (Street, City, State & Zip)

Dates seen:
to

List all Healthcare Providers and Hospitals you have seen for this condition (attach separate sheet, if needed)

Healthcare Provider's Name:

Telephone: ( )
Fax: ( )

Specialty:

Address: (Street, City, State & Zip)

Dates seen:
to

Hospital:

Address: (Street, City, State & Zip)

Dates of Confinement:
to

F. Other Income

Check the other income benefits you have received/are receiving, or are eligible to receive during your disability (complete the information requested).

Source of Income	Amount (week /month)	Date Claim was filed	Date Payments began	Date Payments ended
Social Security: Disability/Retirement	$ _____ / _____			
Social Security: Widow's/Widower's	$ _____ / _____			
Sick Pay or Salary continuation	$_____ / _____			
Income from Work	$_____ / _____			
Workers' Compensation	$_____ / _____			
State Disability	$_____ / _____			
Pension: Disability/Retirement	$_____ / _____			
Public Employee/State Teacher: Retirement/Disability	$_____ / _____			
Short Term Disability	$_____ / _____			
Unemployment	$_____ / _____			
No-Fault Insurance	$_____ / _____			
Other (include individual Group Benefits or Veteran's Benefits)	$_____ / _____			

Are you paying for Medicare Part D? ☐ **Yes** ☐ **No** **If "Yes," please enter amount: _____. 00.**

G. Information about Tax Withholding

Federal law requires us to withhold federal income tax from your check if you request us to do so. We are also required to send a report to your policyholder at the end of each calendar year showing your name, total amount of benefits paid to you, total amount withheld, if any, and your Social Security Number. If you want us to withhold tax, please indicate on the line below the dollar amount to be withheld per week. Whole dollars only (minimum is $20.00 per week): **$_____.00 per week. IMPORTANT:** If your disability benefit is not taxable, you will not be able to request any federal income tax withholding from your check. Puerto Rico residents may not request withholding.

Note to residents of Iowa and the District of Columbia: Should you choose federal income tax withholding, your state requires us to withhold state income tax. We must withhold at a state mandated rate (which may be higher than you need) until we receive a signed state Tax Withholding Certificate from you. Please contact your State Tax Department to obtain the proper withholding form.

Note to residents of Nebraska, Rhode Island, and South Carolina: Should you choose federal income tax withholding, your state requires us to withhold state income tax. We must withhold at a state mandated rate (which may be higher than you need) until we receive a signed federal Form W-4, Employee's Withholding Allowance Certificate, from you. You may go to www.irs.gov to obtain the proper withholding form.

Signature - Please read the statement that applies to your state of residence and sign the bottom of the page.

With the exception of any source(s) of income reported above in this form, I certify by my signature that I have not received and am not eligible to receive any source of income, except for my disability benefits from this plan. Further, I understand that should I receive income of any kind or perform work of any kind during any period The Hartford has approved my disability claim, I must report all details to The Hartford, immediately. If I receive disability income benefits greater than those which should have been paid, I understand that I will be required to provide a lump sum repayment to the Plan. The Hartford has the option to reduce or eliminate future disability payments in order to recover any overpayment balance that is not reimbursed.

For residents of all states EXCEPT Arizona, California, Colorado, Florida, Kentucky, Maine, Maryland, New Jersey, New York, 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 California: For your protection, California law requires the following to appear on this form: Any person who knowingly presents 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 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 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.

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.

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

_____ _____

Signature Date

Electronic Funds Transfer (EFT) is our standard method of payment. When making our claim decision we may contact you to obtain your banking information.

PART - III **AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION**

To: Any health care provider, pharmaceutical provider, pharmacy benefits manager, employer, benefit plan, insurer, service provider, financial institution, educational institution, or Federal, State, or Local Government Agency, including the Social Security Administration and Veterans Administration. **I AUTHORIZE** you to disclose to The Hartford[1] a complete copy of, and to communicate telephonically or electronically with The Hartford's representatives about, any and all of the following personal, private, or privileged information, records, or documents relative to:

Insured's Name (*Please print*)	Date of Birth	Last 4 Digits of Social Security Number

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 drug abuse, and mental health; 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 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 and/or request for accommodation. Such information shall be referred to herein collectively as "My Information." I understand I have the right to revoke this Authorization for future disclosures, except to the extent action has been taken in reliance upon this Authorization. I must revoke this Authorization in writing directly to The Hartford.

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. 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 or adverse or discriminatory treatment related to my claim or condition; c) responding to complaints by me or my representative relating to benefits or leave or accommodation; d) responding to any litigation, agency or regulatory proceeding, 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 or other audits or reviews; (ii) to the administrator 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 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 or reinsurance 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; (ix) as may be reasonably necessary to respond to regulatory complaints; and (x) as may be reasonably necessary to prevent or detect perpetration of a fraud.

I ALSO UNDERSTAND that information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient. I understand that I have the right to revoke this Authorization for future disclosures The Hartford may make, unless The Hartford has taken action in reliance upon this Authorization. I must revoke this Authorization in writing directly to The Hartford. I understand that my medical treatment or payment for medical benefits cannot be conditioned on my allowing The Hartford to re-disclose My Information. The authorizations set forth herein expire two years from the date listed below, or upon my revocation, if earlier, but will not exceed the term of my coverage under the policy(ies) or benefit plan or program, except as may be reasonably necessary to prevent or detect perpetration of a fraud, respond to regulatory complaints, or protect the personal safety of others. I understand that I am entitled to receive a copy of this Authorization upon request. A photocopy or facsimile of this Authorization shall be as valid as the original. If there is a conflict between a prior request for restriction on the disclosure of My Information and this Authorization, this Authorization will control.

Signature of Insured or Authorized Representative	Date (Valid for 2 years)	Relationship to Insured (*if signed by Authorized Representative*)

[1] The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries and their affiliates

Clear Form

Participant Accident
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PART IV - Attending Physician's Statement - Initial Report

To be completed by the Employee

Patient Name:	Date of Birth:	Insured ID Number:

Patient Address: (Street, City, State & Zip Code)

To be completed by the Provider - Use current information from your patient's most recent office visit or examination to complete this form. (The patient is responsible for the completion of this form without expense to the Company.)

Patient's condition is the result of: ☐ Sickness ☐ Injury

Is condition due to illness or an injury that is related to: ☐ Work Activity ☐ Motor Vehicle Accident

Medical Conditions Impacting Activity

Primary condition: _____ ICD-9 Code: ☐ _____ ICD-10 Code: ☐ _____

Secondary condition(s): _____ ICD-9 Code: ☐ _____ ICD-10 Code(s): ☐ _____

Subjective symptoms: _____

Objective Physical Findings (Please include office notes for date(s): _____ to _____

Pertinent Test Results (list all results or attach test results):

Test: _____ Date: _____ Results: _____

Test: _____ Date: _____ Results: _____

Condition(s) Specific Medications, Dosage and Frequency:

Treatments

Date your patient reported stopping work: _____ Date of disability: _____ Expected Return to Work Date: _____

Date you first treated this patient: _____ Date you first treated this patient for this condition: _____

Date of reported onset of this condition: _____ Date of most recent treatment: _____

How often has patient been seen/treated for this condition? _____ Date of next office visit: _____

Current Treatment Plan: _____

Has surgery been performed? ☐ Yes ☐ No Is surgery planned? ☐ 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 of Hospital: _____ Telephone Number of Hospital: (____) _____

Has patient been referred to any other physician? ☐ Yes ☐ No If "Yes," Date(s) of Referral: _____ _____

Other Physician Name: _____ Phone Number: (____) _____ Specialty: _____

Other Physician Name: _____ Phone Number: (____) _____ Specialty: _____

Patient Name: Date of Birth: Insured ID Number:

Complete this section to the best of your ability. Generalized comments such as "unable to work" may delay your patient's disability benefits.

Based on your medical findings and opinion, address the full range of restrictions/limitations at the time patient stopped working, reduced their work schedule or initially visited your office for this condition, noting that we will conclude there are no restrictions on function unless specified below.

Restrictions/Limitations based on office visit dated: _____

In an 8 hour period the patient is able to: (select either continuous or intermittent)

	Continuously with standard breaks		Intermittently with standard breaks	If intermittent circle time for each section below	
				Hours at one time	Total hours/8 hours
Sit	☐	or	☐	1 2 3 4 5 6 7 8	1 2 3 4 5 6 7 8
Stand	☐	or	☐	1 2 3 4 5 6 7 8	1 2 3 4 5 6 7 8
Walk	☐	or	☐	1 2 3 4 5 6 7 8	1 2 3 4 5 6 7 8

Provide medical findings/rationale for your opinion if patient is unable to continuously sit, stand or walk:

_____

_____

Activity Ability (with normal breaks)	Never 0 hours	Occasionally up to 2.5 hours	Frequently 2.5 to 5.5 hours	Constantly 5.5 to 8 hours	Please indicate diagnosis, symptoms, exam findings, and/or imaging that supports the restrictions/limitations
Bend at waist	☐	☐	☐	☐	
Kneel/crouch	☐	☐	☐	☐	
Climb	☐	☐	☐	☐	
Balance	☐	☐	☐	☐	
Drive	☐	☐	☐	☐	
Lift - Indicate weight in pounds		____ lbs.	____ lbs.	____ lbs.	
Other Restrictions (if any)_____	☐	☐	☐	☐	
Hand Dominance: ☐ Right ☐ Left					
Upper Extremity Activity (not load bearing) Specify right (R) or left (L) if not bilateral					
Fine manipulation (fingering, keyboard)	☐	☐	☐	☐	
Gross manipulation (grip/grasp, handle)	☐	☐	☐	☐	
Reach (extend arms) above shoulder	☐	☐	☐	☐	
Reach (extend arms) below shoulder at desk or workbench level	☐	☐	☐	☐	

Please attach copies of imaging results/tests

Expected duration of any restriction(s) or limitation(s) listed above: _____

Current Status (Please check one): ☐ Recovered ☐ Improved ☐ Unchanged ☐ Retrogressed

Additional Comments (If Necessary): _____

Does the patient have a psychiatric / cognitive impairment? ☐ Yes ☐ No If "Yes," please describe the extent of the impairment and its etiology: _____

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

Provider's Name: (please print or type)	EIN Number:	License Number:

Telephone Number: ( )	Fax Number: ( )	Degree:	Specialty:

Street Address (Street, City, State & Zip Code):

Office Contact and Telephone Number:

Provider's Signature: Date signed: