

Group Long-Term Disability Claim

Group Disability Management Services
Mutual of Omaha Insurance Company
United of Omaha Life Insurance Company
Mutual of Omaha Plaza, Omaha, NE 68175
Fax (402) 997-1865 Toll Free (800) 877-5176



Policyholder Name

Group Policy No.

Employer — form completion information

Notice of Claim — Instructions

When it appears your employee's absence will go beyond the end of the policy's elimination period:

- A. **Complete the employer's portion in full and return this portion** to address above or fax to the number above
- Include**
- Copy of approved medical evidence of insurability if required at time of enrollment
 - If Workers' Compensation claim filed include copy of First Report of Accident and the decision
 - Proof of Predisability Earnings i.e., W-2, payroll records, etc. ...
- B. **Give remaining part of form to claimant for completion**

Long-Term Disability Claim Employer's Statement

Please Complete in Full

To Be Completed By The Employer

This claim is for (Employee's Name and Address)	Social Security Number	Date of Birth
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A. Information about the employer

Company's Name	Group Policy Number	Class Number
Address (Mailing, City, State, Zip)	Telephone: ()	Fax: ()
Name and address of division where employee works (if different from above)	Group Policy Division Number	Telephone: ()
		Fax: ()

B. Information about the employee

Date employee was hired (Month, Day, Year)	Date employee became insured under this plan? Date employee became insured under prior plan?	What was the employee's regularly scheduled work week? _____ hours per week _____ hours per day
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C. Information needed for withholding and reporting taxes

Does employee contribute post-tax dollars toward the premium? Yes No If yes, what percent is paid by the employee? _____% Pre-tax _____ Post-tax _____?
If you leave this section blank, we will assume it is 100% employer contribution or any portion paid by the employee is paid with pre-tax dollars and calculate FICA taxes accordingly.

D. Information about the claim

Were there any changes to the employee's job responsibilities due to the disabling condition before the employee became fully disabled?
 Yes No If yes, what were the changes and when were they made?

What was the employee's permanent job on his or her last day at work? _____ How long had the employee been in this job? _____

Last day employee actually worked (Month, Day, Year) _____ On that day, did the employee work a full day?
 Yes No If no, how many hours were worked? _____

Why did employee stop working? _____ Has Employee Returned to Work? _____ Is the employee's condition work related?
Date _____ Yes No

Has a claim been filed with Workers' Compensation?
 Yes No If yes, send initial report of illness or injury and award notice.

Name and Address of your compensation carrier _____

Name and Address of your medical insurance carrier _____ Is this employee covered under a Mutual of Omaha group life policy? Yes No

E. Information for Life Waiver

Is this employee covered under a United of Omaha group life policy? Yes No If yes, Effective Date of Life Insurance _____ Annual Salary _____
Date Insurance Terminated or if not Terminated, "paid to" date _____ Master Policy Number _____ Insurance Class _____ Amount of
Insurance on last day worked _____ Name of beneficiary shown in your records/relationship to insured _____

F. Information about your pension plan (do not complete for maternity claim)

Do you have a pension plan? _____ If yes, what type? Defined benefit 401(k) Other: (specify) _____
 Yes No Defined contribution Profit sharing

Is the employee eligible for your pension plan? _____ If eligible, does the employee participate?
 Yes No If no, why? _____

If the employee is participating, when is he or she eligible for benefits under the plan? (Month, Day, Year) _____

G. Information about your rehire or return-to-work policies

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

What is the name and title of the manager we should contact if we identify a rehabilitation or return-to-work option? _____

H. Information about the employee's salary

The employee (Check all that apply) is paid hourly (what is the hourly rate?) \$ _____ is salaried receives commissions receives bonuses

Will employee file for disability benefits provided by any employer/employee labor management, state disability or union welfare plan?
 Yes No If yes, what is the weekly amount? \$ _____ When do benefits begin? _____ End? _____

Is this employee eligible for salary continuation?
 Yes No If yes, what is the weekly amount? \$ _____ When do benefits begin? _____ End? _____

Is the employee eligible for sick leave? Yes No
If yes, what is the weekly amount: \$ _____ When do benefits begin? _____ End? _____

Based on the definition of Basic Monthly Earnings in your Certificate Booklet, please state the employee's predisability monthly earnings, _____
(Please note: Benefits will be calculated based on premium received.)

X _____ Signature _____ Title _____ Date _____

Long-Term Disability Claim Job Analysis

Please Complete in Full

To Be Completed By The Employee's Supervisor or HR Department (ALL QUESTIONS MUST BE ANSWERED TO AVOID DELAY)

Employer Name	Policy Number
This claim is for (Employee's Name)	Date employee returned to work (Month, Day, Year)
Employee's Social Security Number	First day off work (Month, Day, Year)

A. General information about the employee's job

Job Title	Minimum education or training required
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Does the employee perform supervisory functions?
 Yes No If yes, how many people are supervised? _____ Describe job duties.

How long will the employees job be held open?

Check the items below that relate to the employee's job. Use these definitions for the frequency of occurrence:

Occasionally means the person does the activity up to 33% of the time.

Frequently means the person does the activity 34% to 66% of the time.

Continuously means the person does the activity 67% to 100% of the time.

	Occasionally	Frequently	Continuously
Relate to others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Written and verbal communication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reasoning, math and language	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Makes independent judgments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Which of the following describe the employee's working environment? Check all that apply.

- Unprotected heights
 Changes in temperature or humidity
 Exposure to dust, fumes and gases
 Being near moving machinery
 Driving automotive equipment
 Other hazards

Is the employee required to travel?

Yes No If yes, complete the following information:

How does the employee travel? (Automobile, plane, train, etc.)	Where does the employee travel?	What percent of the time does the employee travel?
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B. Information about the physical aspects of the employee's job

Check the items below that relate to the employee's job and complete the information requested. Use these definitions for the frequency of occurrence:

Occasionally means the person does the activity up to 33% of the time.

Frequently means the person does the activity 34% to 66% of the time.

Continuously means the person does the activity 67% to 100% of the time.

Activity	Frequency of Occurrence			Strength Demands
	Occasionally	Frequently	Continuously	
<input type="checkbox"/> Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	– Sedentary – mostly sitting and lifting up to 10 lbs. – Light – sitting ___ hrs., standing ___ hrs., and lifting up to 25 lbs. – Medium – mostly standing, walking and lifting, 50 lbs. occasionally, 25 lbs. frequently. – Heavy – mostly standing and lifting over 50 lbs. frequently.
<input type="checkbox"/> Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Balancing	<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"/> Kneeling	<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"/> Crawling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Reaching/working overhead	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Climbing:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Number of stairs: _____				
<input type="checkbox"/> Ladders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Height of Ladder: _____				
<input type="checkbox"/> Pushing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Describe Activity _____ lbs.
<input type="checkbox"/> Pulling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____ lbs.
<input type="checkbox"/> Lifting/carrying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____ lbs.

Please Complete in Full (ALL QUESTIONS MUST BE ANSWERED TO AVOID DELAY)

Can the job be performed by alternating sitting and standing?

Yes No

Does the job require using the feet to operate foot controls?

Yes No If yes, on what type of equipment?

How important is good vision in the job?

What are the major tasks requiring use of one or both hands?

One Hand

Both Hands

C. 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 employee assistance in doing the job (through use of technology or personal assistance for example)?

Yes No If yes, explain

D. Attachments and Signature (Attach a copy of the employee's job description)

Name of person completing this form

X _____
Signature

Title

Date

Telephone () Fax ()

E-mail address

Group Long-Term Disability Claim Application

Group Disability Management Services
Mutual of Omaha Insurance Company
United of Omaha Life Insurance Company
Mutual of Omaha Plaza, Omaha, NE 68175
Fax (402) 997-1865



Employee — form completion information

Application for Group LTD — Instructions

- A. **Complete and sign the authorization.** This will allow our insurance carrier or their representative to secure additional information (if necessary) to make a decision on your request for benefit payments (do not detach).
- B. **Complete employee claim statement in full.**
Attach: ● a copy of Social Security and other income entitlement awards (or forward when received)
- C. **Give this authorization and attached claim application to the primary physician treating you.** Instruct your attending physician to send his statement along with yours to the insurance carrier.
- D. When those forms are received by the Insurance Company, they will advise you of your eligibility for benefits or of any additional information that may be needed.

Long-Term Disability Claim Employee's Statement

Please Complete in Full

To Be Completed By The Employee

Policy Number _____

A. Information about you

Last Name		First		Middle Initial		
Address		City		State/Province		Zip
Telephone ()		E-mail Address		Social Security Number		
Date of Birth (Month, Day, Year)	Height	Weight	<input type="checkbox"/> Rt Handed <input type="checkbox"/> Lt Handed	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Single <input type="checkbox"/> Married	<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced

Your Employer (include division if applicable)

Occupation

B. Information about your family (required to determine your eligibility for Social Security benefits)

Spouse's Name (Last, First)

Spouse's Social Security Number	Date of Birth (Month, Day, Year)	Is your spouse employed? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Children under age 25: Name (Last, First)	Date of Birth (Month, Day, Year)
_____	_____
_____	_____
_____	_____

C. Information about the condition causing your disability

1 For **pregnancy** or **illness**, answer the following questions:

What were your first symptoms?

When did you first notice them?	Date you were first treated by a physician (Month, Day, Year)
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2 For an **injury**, answer the following questions:

Where and how did the injury occur?

Date the injury occurred (Month, Day, Year)	Date you were first treated by a physician (Month, Day, Year)
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3 For **illness** or **injury**, answer the following questions:

Why are you unable to work?

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

Is your condition related to your occupation?

Yes No If yes, explain

Have you filed, or do you intend filing a Workers' Compensation claim?

Yes No

D. Information about the disability

Last day you worked before the disability (Month, Day, Year)	Did you work a full day? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, explain	Date you were first unable to work (Month, Day, Year)
-----------------------------------------------------------------	-----------------------------------------------------------------------------------------------------	----------------------------------------------------------

Have you returned to work? <input type="checkbox"/> Yes Part time (date) _____ Full time (date) _____ <input type="checkbox"/> No	If you have not returned to work, do you expect to? <input type="checkbox"/> Yes Part time (date) _____ Full time (date) _____ <input type="checkbox"/> No
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Are you currently self-employed or working for another employer?

Yes No If so, give details.

(Continued on next page)

Please Complete in Full

Policy Number _____

E. Information about physicians and hospitals

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

Doctor's Name	Telephone: () Fax: ()	Specialty
Address (Street, City, State, Zip)		Dates Seen To

List all other physicians and hospitals you have seen for this condition:

Doctor's Name	Telephone: () Fax: ()	Specialty
Address (Street, City, State, Zip)		Dates Seen To

Doctor's Name	Telephone: () Fax: ()	Specialty
Address (Street, City, State, Zip)		Dates Seen To

Doctor's Name	Telephone: () Fax: ()	Specialty
Address (Street, City, State, Zip)		Dates Seen To

Hospital _____

Address (Street, City, State, Zip) _____

Dates of Confinement
To

Have you ever had the same or a similar condition in the past?
 Yes No If yes, complete the following concerning your past treatment:

Doctor's Name	Telephone: () Fax: ()	Specialty
Address (Street, City, State, Zip)		Dates Seen To

Hospital _____

Address (Street, City, State, Zip) _____

Dates of Confinement
To

F. Information about other income benefits

(Check the other income benefits you are receiving or are eligible to receive.)

Source of Income	Amount / (week, month)	Date claim was filed	Date payments began	Date payments ended
Social Security/Retirement	\$ _____ / _____	_____	_____	_____
Social Security/Disability	\$ _____ / _____	_____	_____	_____
Canadian Pension Plan	\$ _____ / _____	_____	_____	_____
Workers' Compensation	\$ _____ / _____	_____	_____	_____
State Disability	\$ _____ / _____	_____	_____	_____
Pension/Retirement	\$ _____ / _____	_____	_____	_____
Pension/Disability	\$ _____ / _____	_____	_____	_____
Short Term Disability	\$ _____ / _____	_____	_____	_____
Unemployment	\$ _____ / _____	_____	_____	_____
No-Fault Insurance	\$ _____ / _____	_____	_____	_____
Other (include individual or group benefits):	\$ _____ / _____	_____	_____	_____

G. Information about income tax withholding

If your request for benefits is approved, should Mutual of Omaha/United of Omaha withhold income taxes from your benefit checks?
 Yes No If yes, how much should be withheld from each check. Federal taxes (minimum is \$87.00 per month) \$ _____ . 00

H. Signature (Required for all claims)

Under what other Mutual of Omaha/United of Omaha policies are you currently covered? _____

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

X _____
Signature of Employee

_____ Date

Group Claim Fraud Statements



The following fraud language is attached to, and made part of this claim form. Please read and do not remove these pages from this claim form.

- ** **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.
- ** **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.
- ** **Arkansas or Louisiana:** 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.
- ** **California:** For your protection California law requires the following to appear on this form. 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.
- ** **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.
- ** **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.
- ** **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.
- ** **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.
- ** **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.
- ** **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.

- ** **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.
- ** **Maine, Tennessee or Virginia:** 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 a denial of insurance benefits.
- ** **Minnesota:** A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.
- ** **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.
- ** **New Jersey:** Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.
- ** **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 CRIMINAL PENALTIES.
- ** **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.
- ** **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.
- ** **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.
- ** **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.
- ** **If you live in a state other than mentioned above, except for New York the following statement applies to you:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer or insurance company, files a statement of claim containing any materially false, incomplete, or misleading information or conceals any fact material thereto, may be guilty of a fraudulent act, may be prosecuted under state law and may be subject to civil and criminal penalties. In addition, any insurer or insurance company may deny benefits if false information materially related to a claim is provided by the claimant.

Authorization to Disclose Personal Information

1. I authorize any physician, medical or dental practitioner, hospital, clinic, pharmacy benefit manager, other medical care facility, health maintenance organization, insurer, employer, consumer reporting agency and any other provider of medical or dental services to release records containing the personal information of:

Claimant/Patient Name: _____
(Last) (First) (Middle)

2. Personal information includes medical history, mental and physical condition, prescription drug records, alcohol or drug use, financial and occupational information.

3. You may release information to:

Group Disability Management Services
Mutual of Omaha Insurance Company/United of Omaha Life Insurance Company
Mutual of Omaha Plaza
Omaha, NE 68175-0001
or
Fax 402-997-1865

4. I understand that the personal information that is disclosed will be used by Mutual of Omaha Insurance Company and United of Omaha Life Insurance Company to evaluate my claim for disability benefit plan reimbursement and that if I refuse to sign this authorization my claim for benefits may not be paid.
5. I understand that if the person or entity to whom information is disclosed is not a health care provider or health plan subject to federal privacy regulations, the personal information may be redisclosed without the protection of the federal privacy regulations.
6. This authorization will expire 24 months after the date signed.
7. I understand that I may revoke this authorization at any time by providing a written request to Mutual of Omaha Insurance Company and United of Omaha Life Insurance at the address above. If I revoke this authorization, it will not affect any use or disclose of personal information that occurred prior to the receipt of my revocation.
8. I understand that I am entitled to receive a copy of this authorization and that a copy is as valid as the original.

Name(s) used for records (if different than the name below): _____

Signature of Claimant

Date

If Applicable: I am the legal representative of the claimant and I am authorized to grant permission on behalf of the claimant.

Printed name of Legal Representative: _____

Signature of Legal Representative: _____

Type of Legal Representative: _____

THIS AUTHORIZATION COMPLIES WITH HIPAA AND OTHER FEDERAL AND STATE LAWS

Long-Term Disability Claim Physician's Statement

Please Complete in Full

Group Disability Management Services
Mutual of Omaha Insurance Company
United of Omaha Life Insurance Company
Mutual of Omaha Plaza, Omaha, NE 68175
Fax (402) 997-1865

This form should be completed by the physician who was treating the claimant when he or she last worked.

To Be Completed By The Attending Physician

A. General Information

This claim is for (Patient's Name)		Employer Name		Policy Number
Patient's Social Security Number	Height	Weight	Blood Pressure	Date of Birth (Month, Day, Year)

B. Complete this section for normal pregnancy, then go to section E.

What was the date of the last menstrual period?	What is the expected date of delivery?	
What is the expected length of postpartum recovery?	What was the first date of treatment?	What was the last date of treatment?

C. Complete this section for all conditions except normal pregnancy.

Primary Diagnosis including ICD 9 or DSM code

Symptoms

Objective Findings

What diagnostic testings have been done?

Are there secondary conditions contributing to the disability?
 Yes No If yes, what are they? (Please include ICD 9 or DSM code.)

If this is a cardiac condition, what is the functional capacity? (American Heart Association)
 Class 1 - No limitation Class 2 - Slight limitation Class 3 - Marked limitation Class 4 - Complete limitation

When did symptoms first appear?	Date of the patient's first visit (Month, Day, Year)	Date you believe the patient was first unable to work (Month, Day, Year)
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Date of the patient's last visit (Month, Day, Year)	How often do you see the patient?
-----------------------------------------------------	-----------------------------------

Is the patient's condition work related?
 Yes No If yes, explain:

Has the patient undergone surgery?
 Yes No If yes, give date, procedure and result.

If no, do you expect surgery to be performed in the future?
 Yes No If yes, give date and type of surgery.

What medication is the patient currently taking or has been prescribed?

Please indicate other types and frequencies of treatment.

Has the patient been referred to a medical rehabilitation or therapy program?
 Yes No If yes, give details.

Have you referred the patient for other types of consultations?
 Yes No If yes, give details.

Has the patient been hospital confined?
 Yes No If yes, complete the following:

Name of Hospital

Address	Dates of Confinement through
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D. Information about the patient's inability to work

Briefly describe restrictions and limitations.

Restrictions (What the patient SHOULD NOT do)

Limitations (What the patient CANNOT do)

What is your prognosis for recovery?

Has patient achieved maximum medical improvement?
 Yes No If no, complete the following:

How soon do you expect fundamental changes in the patient's medical condition?
 1 - 2 months 5 - 6 months 1 year or more
 3 - 4 months 6 months to 1 year Never

Give details concerning expected improvement or deterioration:

What is your treatment plan for patients return to work or return to prior level of function?

In an eight hour workday, claimant can: *(Circle full hourly capacity for each activity)*

Sit	1	2	3	4	5	6	7	8
Stand	1	2	3	4	5	6	7	8
Walk	1	2	3	4	5	6	7	8

Are there restrictions in:	Yes	No	Comments: If "Yes," please explain fully below
Lifting/Carrying	<input type="checkbox"/>	<input type="checkbox"/>	_____
Use of hands in repetitive actions	<input type="checkbox"/>	<input type="checkbox"/>	_____
Use of feet in repetitive movements	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bending	<input type="checkbox"/>	<input type="checkbox"/>	_____
Squatting	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crawling	<input type="checkbox"/>	<input type="checkbox"/>	_____
Climbing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Reaching above shoulder level	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other (please specify)	<input type="checkbox"/>	<input type="checkbox"/>	_____

When do you expect claimant to return to prior level of functioning?

Would you recommend vocational rehabilitation for this patient?
 Yes No

E. Required Attachments and Signature

- After you have fully completed this form, attach copies of the following materials:**
- Office notes for the period of treatment for the last two years
 - Test results showing objective findings
 - Hospital discharge summaries
 - Consulting physician reports

Your Name	Degree
Specialty	Telephone: () Fax: ()
Address	