



INTEGRATED LEAVE CLAIM

Short Term Disability (STD) and Massachusetts Paid Family and Medical Leave (MA PFML)
**FOR QUESTIONS, CONTACT CUSTOMER SERVICE AT 1-800-370-5856,
MONDAY THROUGH FRIDAY, 8 A.M. TO 5 P.M. CST.**

WHERE TO SUBMIT YOUR CLAIM:

Attention: Claims Department
Mail: P.O. Box 1650 | Little Rock | AR | 72203
Email: claims@usablelife.com | **Fax:** (501) 235-8417
Online Application: USABLELife.com/claims

Note: This claim form can be used for:

- **STD claim**
- **Medical Leave for your own serious health condition**
- **Family Leave to care for a family member with a serious health condition (including a condition related to military service)**
- **Parental Leave to bond with a child 12 months after birth, adoption, or foster care placement**
- **Active Duty Leave to manage family affairs when a family member is in the armed forces**

If you have an STD claim with a concurrent MA PFML claim for your own serious health condition (disability), only one form is required.

STEP 1 KNOW YOUR PLAN

Pick up a copy of your certificate of coverage from your employer’s benefits department to locate your benefit plan’s maximum benefit duration, waiting period, benefit calculation, and other key provisions the policy may contain.

STEP 2 OBTAIN THE REQUIRED DOCUMENTS

To process your disability claim, please submit the following documents:

You complete Section 1:

- COVERED INDIVIDUAL STATEMENT
- AUTHORIZATION TO RELEASE
- FRAUD NOTICE

Your employer completes Section 2:

- EMPLOYER STATEMENT

Your or your family member’s physician completes Section 3*:

- ATTENDING PHYSICIAN STATEMENT/CERTIFICATION

*You must complete the top section of Section 3: “Covered Individual Information – Section to be completed by Covered Individual.”

- If you are filing a Family or Military Leave claim, you must provide proof of your family relationship to the individual who requires your care or companionship. This proof could be a birth certificate, court document, or other documentation that clearly shows familial relationship.
- Additional forms or information may be required depending on the type of leave being requested.
- The covered individual requesting leave is responsible for the submission of these forms.
- Items in gray boxes are specific to MA PFML. If you are only filing an STD claim, these sections are not required.
- Section 3: Attending Physician Statement/certification is not required for Parental Leave or Active Duty Leave claims.
- Covered individual refers to employee covered under the employer’s STD or MA PFML plan and is sometimes referred to as employee or claimant. This is the individual applying for leave.

STEP 3 SUBMIT YOUR CLAIM FORM & DOCUMENTS

To submit your claim via email, scan and email your documents to claims@usablelife.com. You can also send your claim via fax to 501-235-8417, or by mail to ATTN: Claims Department, P.O. Box 1650, Little Rock, AR 72203. Please note, the Covered Individual Statement and the Employer Statement can also be completed and submitted online by the covered individual and the employer respectively by going to USABLELife.com/claims.

STEP 4 RETURN YOUR COMPLETED UPDATE FORM

If your claim is approved, USABLE Life may require recertification forms to be completed by you or your family member’s health care provider. These forms help us track recovery while you are on leave. Recertification forms are also available online at USABLELife.com.



INTEGRATED LEAVE CLAIM FORM: Section 1

PLEASE RETURN ALL STATEMENTS ATTENTION: Claims Department | P.O. Box 1650 | Little Rock, AR 72203 | EMAIL: claims@usablelife.com | FAX: (501) 235-8417

COVERED INDIVIDUAL STATEMENT - TO BE COMPLETED BY THE COVERED INDIVIDUAL

DEMOGRAPHIC INFORMATION OF COVERED INDIVIDUAL

1. Covered Individual's Name (First, MI, Last)	2. Date of Birth	3. Social Security Number	4. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other
5. Street Address (Address, City, State, ZIP)		6. Home Phone Number	
		7. Cell Phone Number	
8. Mailing Address (If different than Street Address)		9. Email Address	
10. Do you authorize us to communicate with you by email? <input type="checkbox"/> Yes <input type="checkbox"/> No		11. Do you authorize us to leave detailed messages on your primary phone number? <input type="checkbox"/> Yes <input type="checkbox"/> No	

DEMOGRAPHIC INFORMATION OF FAMILY MEMBER FOR WHOM COVERED INDIVIDUAL IS PROVIDING CARE (if applicable)

12. Family Member's Name (First, MI, Last)	13. Date of Birth	14. Social Security Number	15. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other
16. Please describe your relationship to this person:			
17. Please describe the nature of the care you will provide for your family member:			

LEAVE INFORMATION

18. What is the reason for your leave? <input type="checkbox"/> Own Serious Health Condition <input type="checkbox"/> Bond with Child <input type="checkbox"/> Care for Family Member <input type="checkbox"/> Military Leave <input type="checkbox"/> Care for Family Member in the Military			
19. How many days do you regularly work per week (1-7):		20. Is this leave request: Continuous, Reduced Schedule, or Intermittent?	
21. If Continuous leave is requested: Start Date _____ End Date _____		22. If Reduced Schedule is being requested: Start Date _____ End Date _____ Hours per work day _____ Days worked/week _____	
23. If Intermittent leave is being requested, please list the dates that will be taken if already known or already taken:			
24. Are you currently employed <input type="checkbox"/> Yes <input type="checkbox"/> No	25. Occupation	26. Last Day Actively at Work	27. First Full Day of Leave/Disability
28. Expected Return Date	29. What main or material duties of your job are you not able to perform as a result of your condition?		
30. Date Symptoms First Appeared	31. Date of First Treatment	32. Hospital/physician of First Treatment	
33. This claim is for: <input type="checkbox"/> Pregnancy <input type="checkbox"/> Illness <input type="checkbox"/> Accident	34. Nature of Illness	35. Have you previously suffered from this or a similar condition? <input type="checkbox"/> No <input type="checkbox"/> Yes, on Date _____ Please Describe	
	PLEASE PROVIDE A COPY OF THE INCIDENT OR ACCIDENT REPORT IF ONE IS AVAILABLE		
	36. Date of Accident	37. Time of Accident : <input type="checkbox"/> AM <input type="checkbox"/> PM	38. How and Where the Accident Occurred
39. Did the disabling accident occur while performing the duties of your job? <input type="checkbox"/> No <input type="checkbox"/> Yes (please explain)			
40. Was your disability sustained in a Motor Vehicle Accident (MVA)? If so, what was your role in the accident? <input type="checkbox"/> No, my disability is not the result of a MVA <input type="checkbox"/> Yes, I was the driver <input type="checkbox"/> Yes, I was a passenger			
41. Was your disability sustained in an accident in which a third party was at fault? <input type="checkbox"/> No <input type="checkbox"/> Yes (please explain)			

PLEASE LIST ALL PHYSICIANS YOU HAVE SEEN WITHIN THE LAST TWO YEARS. (USE AN ADDITIONAL SHEET OF PAPER IF NECESSARY)

Physician's Name	Date Treated	Condition Treated	Address/City/State/ZIP

EMPLOYMENT INFORMATION

42. My present employer is: (or last employer if unemployed) Name and address - include street, city, state and ZIP code: _____ _____ _____	43. Prior to my disability, I worked for this employer: From _____ to _____ (month) (day) (year) (month) (day) (year)				
	44. I worked: _____ hours per week and I earned: _____ per week				
45. I informed my employer of my request for leave on: How? <input type="checkbox"/> In writing <input type="checkbox"/> In person <input type="checkbox"/> By telephone <input type="checkbox"/> Other <input type="checkbox"/> Unknown	46. I am a union member <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, name of union: _____				
47. Other employers I worked for during the past 52 weeks. Employer's name and address: a. _____ b. _____ c. _____ d. _____	Period of Employment			Weekly	
	From: (mo/day/year)	To: (mo/day/year)		Hours	Wages

OTHER INCOME YOU RECEIVED, FILED FOR, OR ARE ELIGIBLE FOR. PLEASE INCLUDE A COPY OF YOUR AWARD OR DENIAL LETTER.

✓	Benefit Source	Gross Amount	Benefit Frequency		Date Applied For	Date Benefits Begin
<input type="checkbox"/>	Workers' Compensation	\$	Weekly	Monthly		
<input type="checkbox"/>	State Disability Income	\$	Weekly	Monthly		
<input type="checkbox"/>	Unemployment	\$	Weekly	Monthly		
<input type="checkbox"/>	Other _____	\$	Weekly	Monthly		

OVERPAYMENT NOTICE: IF USABLE LIFE SHOULD OVERPAY YOUR BENEFITS AT ANY TIME DURING THE DURATION OF THIS CLAIM, WE WILL REQUEST REIMBURSEMENT OF THE OVERPAID AMOUNT. YOUR SIGNATURE ON THIS FORM AUTHORIZES USABLE LIFE TO RECOVER ANY OVERPAID MEDICARE AND/OR SOCIAL SECURITY TAX THAT WAS PAID ON YOUR BEHALF AND CERTIFIES YOU WILL NOT ATTEMPT TO RECOVER A REFUND OR CREDIT OF THE MEDICARE AND/OR SOCIAL SECURITY TAX WITH ANY FORM W-2C THAT IS FURNISHED TO YOU BASED ON RECOVERIES RECEIVED. PLEASE LET US KNOW WHEN YOU RETURN TO WORK TO AVOID AN OVERPAYMENT.

48. SIGN & DATE BELOW

Covered Individual's Name Printed (First, MI, Last)	Covered Individual's Signature	Date
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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I hereby request and authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, other health care provider, healthcare clearinghouse, insurance company, reinsurer, MIB, or consumer reporting agency ("providers") that has provided payment, treatment, or services to me to disclose the entire medical record and any other protected health information concerning me to USSMAble Life and its agents, employees, legal representatives, reinsurers, and the MIB. This includes information on the diagnosis of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict protected health information do not apply to this authorization, and I instruct any providers to release and disclose the entire medical record without restriction.

This protected health information is to be disclosed under this authorization so that USSMAble Life may:

1. Administer claims and determine or fulfill responsibility for coverage and provision of benefits;
2. Administer coverage; and
3. Conduct other legally permissible activities that relate to any coverage I have or have applied for with USSMAble Life.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to Customer Service, USSMAble Life, P.O. Box 1650, Little Rock, AR 72203-1650, or to custserv@usablelife.com. I understand that a revocation is not effective to the extent that any of the providers have relied on this authorization or to the extent that USSMAble Life has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information disclosed pursuant to this authorization may be redisclosed and is no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that the providers may not refuse to provide treatment if I refuse to sign this authorization. However, I further understand that if I refuse to sign this authorization to release complete medical records, USSMAble Life may deny my claim for benefits. I acknowledge that I have received a copy of this authorization.

SIGN & DATE BELOW

Covered Individual's Name Printed (First, MI, Last)	Covered Individual's Signature	Date
Claimant's Name Printed (First, MI, Last) - <i>if other than Covered Individual</i>	Claimant's Signature - <i>if other than Covered Individual</i>	Date

THIRD-PARTY SHARING

I authorize USSMAble Life to use and disclose my information (including my name, Social Security number, and disability claim information) to (i) third party administrators involved in claims processing (ii) other service providers, including health and wellness benefit plans or programs. I understand that if I do not wish to participate in the information disclosure under item (ii), I may request to opt out at USSMAbleLife.com/dis-opt-out, by calling 1-800-370-5856, upon which I will be asked to verify my identity, or by checking the box below to process my opt-out request.

Do not provide my disability claim information to USSMAble Life's health and wellness benefit plans or programs.

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FOR YOUR PROTECTION, THE LAWS OF SOME STATES MAY REQUIRE US TO FURNISH YOU WITH THE FOLLOWING NOTICE: 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. Please see below for special notices required by state law for residents.

AL	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.
AK	Any 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.
AZ	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.
CA	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.
CO	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.
DE	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.
DC	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.
FL	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.
ID	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.
IN	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.
KS	Fraudulent insurance act defined; amount involved defined; penalty; notification of commissioner, when; antifraud plan. (a) For purposes of this act a "fraudulent insurance act" means an act committed by any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance that such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto.
KY	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.
ME	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.

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MD	Any person who knowingly or willfully presents a false or fraudulent claim for payment of 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.
MN	A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.
NH	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.
NJ	Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.
NM	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.
OH	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 is guilty of insurance fraud.
OK	WARNING: Any person who knowingly, and with intent to injure, defraud or deceive an insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.
OR	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 subject to fines and confinement in prison.
PA	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.
RI	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.
TN	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.
TX	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.
VA	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.
VT	Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.
WA	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.


SIGN AND DATE BELOW (I have read and understand the Fraud Notice that applies to my state of residence.)

Name (last, first, middle)	Telephone No.
Signature	Date

OTHER INCOME PAID AFTER COVERED INDIVIDUAL'S LAST DAY WORKED (PLEASE CHECK & COMPLETE ALL THAT APPLY.)

Pay Source	Weekly Amount	Paid-through Date	Has a Workers' Compensation claim been filed or expected to be filed? <input type="checkbox"/> No <input type="checkbox"/> Yes, please provide a copy of the first injury report
Sick Pay	\$ _____		Name and Address of Workers' Compensation Carrier: _____ _____ _____ Do you have STD or MA PFML with another carrier? <input type="checkbox"/> No <input type="checkbox"/> Yes, please specify Name and Address of Carrier: _____ _____ _____
Vacation/PTO	\$ _____		
Salary Continuation	\$ _____		
Commissions	\$ _____		

IMPORTANT: PLEASE CONTACT YOUR PAYROLL OR HUMAN RESOURCES DEPARTMENT FOR THE FOLLOWING INFORMATION.

25. Total Year-to-Date Social Security Wages Paid: \$ _____ as of Date: _____	
26. Total Year-to-Date Medicare Taxable Wages Paid: \$ _____ as of Date: _____	
27. What percentage of the STD premium is paid by the Employer: _____ %	28. What percentage of the STD premium is paid by the Covered Individual: _____ %
Percentages in 27 and 28 must add up to 100%.	
29. Are Employer-paid STD premiums included in the Covered Individual's taxable wages/salary? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	30. Are Covered Individual-paid STD premiums paid with pre-tax dollars (IRC Section 125 Cafeteria Plans)? <input type="checkbox"/> Yes <input type="checkbox"/> No
31. What percentage of the PML premium is paid by the Employer: _____ %	32. What percentage of the PML premium is paid by the Covered Individual: _____ %
Percentages in 31 and 32 must add up to 100%.	
33. Are Employer-paid PML premiums included in the Covered Individual's taxable wages/salary? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	34. Are Covered Individual-paid PML premiums paid with pre-tax dollars (IRC Section 125 Cafeteria Plans)? <input type="checkbox"/> Yes <input type="checkbox"/> No
35. What percentage of the PFL premium is paid by the Employer: _____ %	36. What percentage of the PFL premium is paid by the Covered Individual: _____ %
Percentages in 35 and 36 must add up to 100%.	
37. Are Employer-paid PFL premiums included in the Covered Individual's taxable wages/salary? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	38. Are Covered Individual-paid PFL premiums paid with pre-tax dollars (IRC Section 125 Cafeteria Plans)? <input type="checkbox"/> Yes <input type="checkbox"/> No
 FRAUD WARNING: 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.	
39. Employer's Name	
40. Employer's Mailing Address (Address, City, State, ZIP)	
41. Contact Name	42. Contact Phone Number
43. Contact Fax Number	44. Contact Email Address
45. Contact Signature	46. Contact Title
47. Date	

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COVERED INDIVIDUAL INFORMATION – SECTION TO BE COMPLETED BY COVERED INDIVIDUAL

1. Which of the following best describes this request for leave? <input type="checkbox"/> Leave for your own medical condition <input type="checkbox"/> Leave for care of a family member		
2. Covered Individual's Name (First, MI, Last)	3. Date of Birth	4. Social Security Number
5. Mailing Address (Address, City, State, ZIP)		
6. Patient's Name (if different than above) (First, MI, Last)	7. Date of Birth	8. Social Security Number
9. Patient's Address (Address, City, State, ZIP)		

**ATTENDING PHYSICIAN STATEMENT/CERTIFICATION
SECTION TO BE COMPLETED BY THE PHYSICIAN**

LEAVE INFORMATION

10. Does the patient require care by the covered individual requesting Paid Family Leave? <input type="checkbox"/> Yes <input type="checkbox"/> No		
11. First Date care for patient is needed?	12. Expected Date patient will no longer need care:	
13. Estimated number or days per week or days per month patient requires care: <input type="checkbox"/> Days/Weeks: or <input type="checkbox"/> Days/Months:		
14. Please describe the type of care the covered individual requesting leave will have to provide to your patient:		
15. Disabling Diagnosis and Concurrent Conditions:		16. ICD Code: 1. 2.
17. This disability is due to: <input type="checkbox"/> Accident <input type="checkbox"/> Illness <input type="checkbox"/> Pregnancy	18. Is this condition the result of a work-related injury or illness? <input type="checkbox"/> No <input type="checkbox"/> Yes, please explain	
19. If disability is due to an accident involving the Covered Individual, how and where did the accident occur?		
20. If disability is due to pregnancy: Date of LMP	Delivery Date <input type="checkbox"/> Actual <input type="checkbox"/> Estimated	Type of Delivery <input type="checkbox"/> Vaginal <input type="checkbox"/> C-Section
21. Date Symptoms First Appeared:	22. Date of First Visit for Current Condition:	23. Date of Next Appointment:
24. What date was the patient first unable to work due to disability?	25. What date did you first discuss the possibility of the patient being unable to continue working due to disability?	
26. Please advise if this will be: <input type="checkbox"/> Continuous Leave <input type="checkbox"/> Reduced Schedule <input type="checkbox"/> Intermittent Leave		
27. In your opinion, on what date will/did the patient recover sufficiently to return to work?	28. If recovery date not determined, when will they be re-evaluated?	
29. If due to the condition, it is medically necessary for the patient to work on an intermittent basis (periodically), please complete the below: From _____ (date) To _____ (date)	30. If due to the condition, it is medically necessary for the patient to work a reduced schedule, please complete the below: The patient is able to work: _____ (e.g., 4 hours/day; up to 20 hours a week)	
31. Has the patient ever had the same or similar condition? <input type="checkbox"/> No <input type="checkbox"/> Yes, on what date?		
32. Please list all treatment dates during the month the disability began:	33. Did another physician treat/or will be treating the patient? <input type="checkbox"/> No <input type="checkbox"/> Yes, on what date?	

34. Other Physician's Name		35. Other Physician's Phone Number	
36. Please list the dates and types of surgical procedures related to this condition:			
37. Were there any complications that caused your patient to stop working prior to the expected surgery or delivery? <input type="checkbox"/> No <input type="checkbox"/> Yes, please explain			
38. Was your patient hospitalized? <input type="checkbox"/> No <input type="checkbox"/> Yes		<input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient	
		Date Admitted	Date Discharged
39. Full Hospital Name			
40. Hospital Address		41. Hospital Phone Number	
42. What functional restrictions and limitations have been placed on the patient? Please be specific and understand that a reply of "no work" will not allow us to evaluate the claim for benefits.			
43. What is the planned course and duration of treatment, including medications?			
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44. Are you related to this patient? <input type="checkbox"/> No <input type="checkbox"/> Yes, what is the relationship?			
45. Physician's Signature		46. Degree/Prof. Designation	47. Date
48. Physician's Name Printed (First, Last)		49. Physician's Phone Number	50. Physician's Fax Number
51. Physician's Mailing Address (Address, City, State, ZIP)			
52. If necessary, whom may we contact at your office for more information?			53. Contact Phone Number