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 employers 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.

USAble Life℠

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 ☐ Male ☐ Female ☐ Other

5. Street Address (Address, City, State, ZIP)	6. Primary Phone Number
7. Mailing Address (If different than Street Address)	8. Email Address
9. Do you authorize us to communicate with you by email? ☐ Yes ☐ No	10. Do you authorize us to leave detailed messages on your primary phone number? ☐ Yes ☐ No

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

11. Family Member's Name (First, MI, Last)	12. Date of Birth	13. Social Security Number	14. Gender ☐ Male ☐ Female ☐ Other

15. Please describe your relationship to this person:

16. Please describe the nature of the care you will provide for your family member:

LEAVE INFORMATION

17. What is the reason for your leave?
☐ Own Serious Health Condition ☐ Bond with Child ☐ Care for Family Member ☐ Military Leave ☐ Care for Family Member in the Military

18. How many days do you regularly work per week (1-7):	19. Is this leave request: Continuous, Reduced Schedule, or Intermittent?
20. If Continuous leave is requested: Start Date _______________ End Date _______________	21. If Reduced Schedule is being requested: Start Date_______________ End Date _______________ Hours per work day_______________ Days worked/week _______________

22. If Intermittent leave is being requested, please list the dates that will be taken if already known or already taken:

23. Are you currently employed ☐ Yes ☐ No	24. Occupation	25. Last Day Actively at Work	26. First Full Day of Leave/Disability

27. Expected Return Date	28. What main or material duties of your job are you not able to perform as a result of your condition?

29. Date Symptoms First Appeared	30. Date of First Treatment	31. Hospital/physician of First Treatment

32. This claim is for:
☐ Pregnancy
☐ Illness
☐ Accident

33. Nature of Illness	34. Have you previously suffered from this or a similar condition? ☐ No ☐ Yes, on Date Please Describe

PLEASE PROVIDE A COPY OF THE INCIDENT OR ACCIDENT REPORT IF ONE IS AVAILABLE

35. Date of Accident	36. Time of Accident : ☐ AM ☐ PM	37. How and Where the Accident Occurred

38. Did the disabling accident occur while performing the duties of your job?
☐ No ☐ Yes (please explain)

39. Was your disability sustained in a Motor Vehicle Accident (MVA)? If so, what was your role in the accident?
☐ No, my disability is not the result of a MVA ☐ Yes, I was the driver ☐ Yes, I was a passenger

40. Was your disability sustained in an accident in which a third party was at fault?
☐ No ☐ Yes (please explain)

RETURN THE ORIGINAL TO USABLE LIFE AND RETAIN A COPY FOR YOUR RECORDS.

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

41. My present employer is: (or last employer if unemployed)
Name and address - include street, city, state and ZIP code:

____

____

____

42. Prior to my disability, I worked for this employer:
From____________________to____________________
(month) (day) (year) (month) (day) (year)

43. I worked:____________________hours per week
and
I earned:____________________per week

44. I informed my employer of my request for leave on:
How? In writing In person Telephone Other Unknown

45. I am a union member ☐ No ☐ Yes
If yes, name of union:

46. Other employers I worked for during the past 52 weeks. Employer's name and address:	Period of Employment						Weekly	
	From: (mo/day/year)			To: (mo/day/year)			Hours	Wages
a.								
b.								
c.								
d.								

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
☐	Workers' Compensation	$	Weekly Monthly		
☐	State Disability Income	$	Weekly Monthly		
☐	Unemployment	$	Weekly Monthly		
☐	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.

47. SIGN & DATE BELOW		
Covered Individual's Name Printed (First, MI, Last)	Covered Individual's Signature	Date

RETURN THE ORIGINAL TO USABLE LIFE AND RETAIN A COPY FOR YOUR RECORDS.

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 USAble 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 USAble 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 USAble 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, USAble 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 USAble 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, USAble 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) - *if other than Covered Individual*	Claimant's Signature - *if other than Covered Individual*	Date

RETURN THE ORIGINAL TO USABLE LIFE AND RETAIN A COPY FOR YOUR RECORDS.

USABLE LIFE℠ | FRAUD NOTICE

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.

AL Residents Only: 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 Residents Only: 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 Residents Only: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

CA Residents Only: 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 Residents Only: 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, ID, IN, OK Residents Only: 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 Residents Only: 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 Residents Only: 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 of the third degree.

KS Residents Only: 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 as determined by a court of law.

KY Residents Only: 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 and TN Residents Only: 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.

MD, RI, TX Residents Only: 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 Residents Only: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

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

OH Residents Only: 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.

OR Residents Only: 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 Residents Only: 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.

VT Resident Only: 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.

VA and WA Residents Only: 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 Warning that applies to my state of residence.

LAST NAME, FIRST NAME, MI *(PRINTED)*	SIGNATURE	TODAY'S DATE

USAble Life℠

INTEGRATED LEAVE FORM: Section 2

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

EMPLOYER STATEMENT - TO BE COMPLETED BY THE EMPLOYER

✓ **CLAIM SUBMISSION CHECKLIST:** ☐ COPY OF ENROLLMENT CARD OR PROOF OF COVERAGE ☐ COPY OF COVERED INDIVIDUAL'S JOB DESCRIPTION

1. Covered Individual's Name (First, MI, Last)	2. Date of Birth	3. Social Security Number
4. Mailing Address (Address, City, State, ZIP)		
5. Occupation/job Title	6. Group Policy Number	7. Date of Hire

8. Regular Number of Hours Worked_________ Per Week

9. Regular Days Worked ☐ Mon ☐ Tue ☐ Wed ☐ Thur ☐ Fri ☐ Sat ☐ Sun

10. In reporting wage information below, use gross wages, which include wages and all other remuneration such as commissions, bonuses, tips, and the cash value of meals, lodging, etc. Answer either A, B, or C.

A. If covered individual was paid on a salary basis, enter covered individual's weekly or monthly salary earned in the last week or month prior to the date covered individual's disability began:

Week $___________Month $___________

B. If paid on an hourly basis, give rate per hour

$___________________________________

C. If covered individual received any or all earnings on a commission or piecework basis, enter these earnings for the last 52 weeks prior to the date covered individual's disability began:

This covers the period:

From______________To______________
(month/day/year) (month/day/year)

Earnings: $ _________________________

11. Current Pay Effective Date:_____________________

12. Enter the total wages the covered individual received in the last 4 quarters:

Calendar Quarter Ending	No. of Weeks Worked	Total Wages Earned

13. In the preceding 52 weeks has the covered individual taken leave?
☐ No ☐ Yes, please describe

14. Enter the total number of weeks and days taken for Disability and PMFL in the last 52 weeks (please provide printout of days if available):

Disability: _______ Weeks _______ Days

MA PFML: _______ Weeks _______ Days

15. Is the covered individual taking FMLA, or any other leaves concurrently with this one?
☐ No ☐ Yes, please specify

16. What date did the covered individual inform you of their leave request?

17. Coverage Benefit Amount $__________________ Per Week

18. Coverage Effective Date

19. Covered Individual's Class Number or Description

20. Last Day Actively at Work____________ # of Hrs______

21. Date Returned To Work ___________________ ☐ Full-time ☐ Part-time

22. As the employer, would you be able to accommodate modified duty to facilitate early return to work?
☐ No ☐ Yes, Please explain (reduced hours, job modifications, etc.)

PLEASE CHECK THE BOX BELOW THAT BEST DESCRIBES THE COVERED INDIVIDUAL'S JOB DUTIES.

☐ Sedentary	☐ Light	☐ Medium	☐ Heavy	☐ Very Heavy	☐ Other
Lift negligible weight Mostly sitting	Lift up to 10 lbs. frequently; up to 20 lbs. occasionally and/or frequently walk/ stand and/or push/pull	Lift up to 25 lbs. frequently; up to 50 lbs. occasionally	Lift 25 to 50 lbs. frequently; 50 to 100 lbs. occasionally	Lift over 50 lbs. frequently; 100 lbs. occasionally	Please describe

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

Pay Source	Weekly Amount	Paid-through Date
Sick Pay	$_______________	
Vacation/PTO	$_______________	
Salary Continuation	$_______________	
Commissions	$_______________	

Has a Workers' Compensation claim been filed or expected to be filed?
☐No ☐Yes, please provide a copy of the first injury report

Name and Address of Workers' Compensation Carrier:

____

____

____

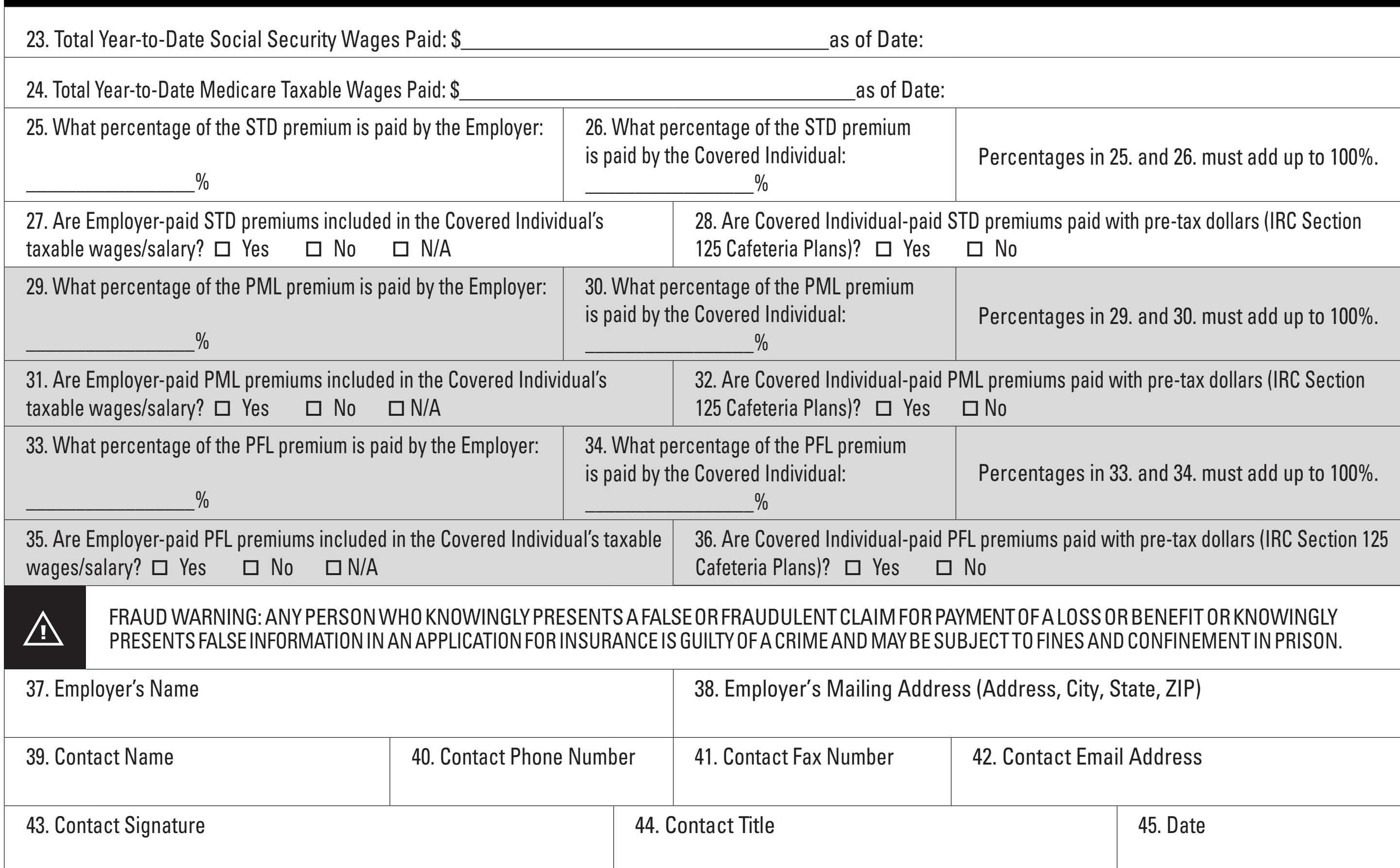
Do you have STD or MA PFML with another carrier?
☐No ☐Yes, please specify

Name and Address of Carrier:

____

____

____



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

23. Total Year-to-Date Social Security Wages Paid: $___________________________________as of Date:

24. Total Year-to-Date Medicare Taxable Wages Paid: $_____________________________________as of Date:

25. What percentage of the STD premium is paid by the Employer: _______________%	26. What percentage of the STD premium is paid by the Covered Individual: _______________%	Percentages in 25. and 26. must add up to 100%.

27. Are Employer-paid STD premiums included in the Covered Individual's taxable wages/salary? ☐ Yes ☐ No ☐ N/A

28. Are Covered Individual-paid STD premiums paid with pre-tax dollars (IRC Section 125 Cafeteria Plans)? ☐ Yes ☐ No

29. What percentage of the PML premium is paid by the Employer: _______________%	30. What percentage of the PML premium is paid by the Covered Individual: _______________%	Percentages in 29. and 30. must add up to 100%.

31. Are Employer-paid PML premiums included in the Covered Individual's taxable wages/salary? ☐ Yes ☐ No ☐ N/A

32. Are Covered Individual-paid PML premiums paid with pre-tax dollars (IRC Section 125 Cafeteria Plans)? ☐ Yes ☐ No

33. What percentage of the PFL premium is paid by the Employer: _______________%	34. What percentage of the PFL premium is paid by the Covered Individual: _______________%	Percentages in 33. and 34. must add up to 100%.

35. Are Employer-paid PFL premiums included in the Covered Individual's taxable wages/salary? ☐ Yes ☐ No ☐ N/A

36. Are Covered Individual-paid PFL premiums paid with pre-tax dollars (IRC Section 125 Cafeteria Plans)? ☐ Yes ☐ 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.

37. Employer's Name	38. Employer's Mailing Address (Address, City, State, ZIP)

39. Contact Name	40. Contact Phone Number	41. Contact Fax Number	42. Contact Email Address

43. Contact Signature	44. Contact Title	45. Date

RETURN THE ORIGINAL TO USABLE LIFE AND RETAIN A COPY FOR YOUR RECORDS.

USAble Life[SM]

INTEGRATED LEAVE FORM: Section 3

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 INFORMATION – SECTION TO BE COMPLETED BY COVERED INDIVIDUAL

1. Which of the following best describes this request for leave?
☐ Leave for your own medical condition ☐ 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? ☐ Yes ☐ 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:
☐ Days/Weeks: or ☐ 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: ☐ Accident ☐ Illness ☐ Pregnancy	18. Is this condition the result of a work-related injury or illness? ☐ No ☐ 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 ☐ Actual ☐ Estimated	Type of Delivery ☐ Vaginal ☐ C-Section
21. Date Symptoms First Appeared:	22. Date of First Visit for Current Condition:	23. Date of Next Appointment:

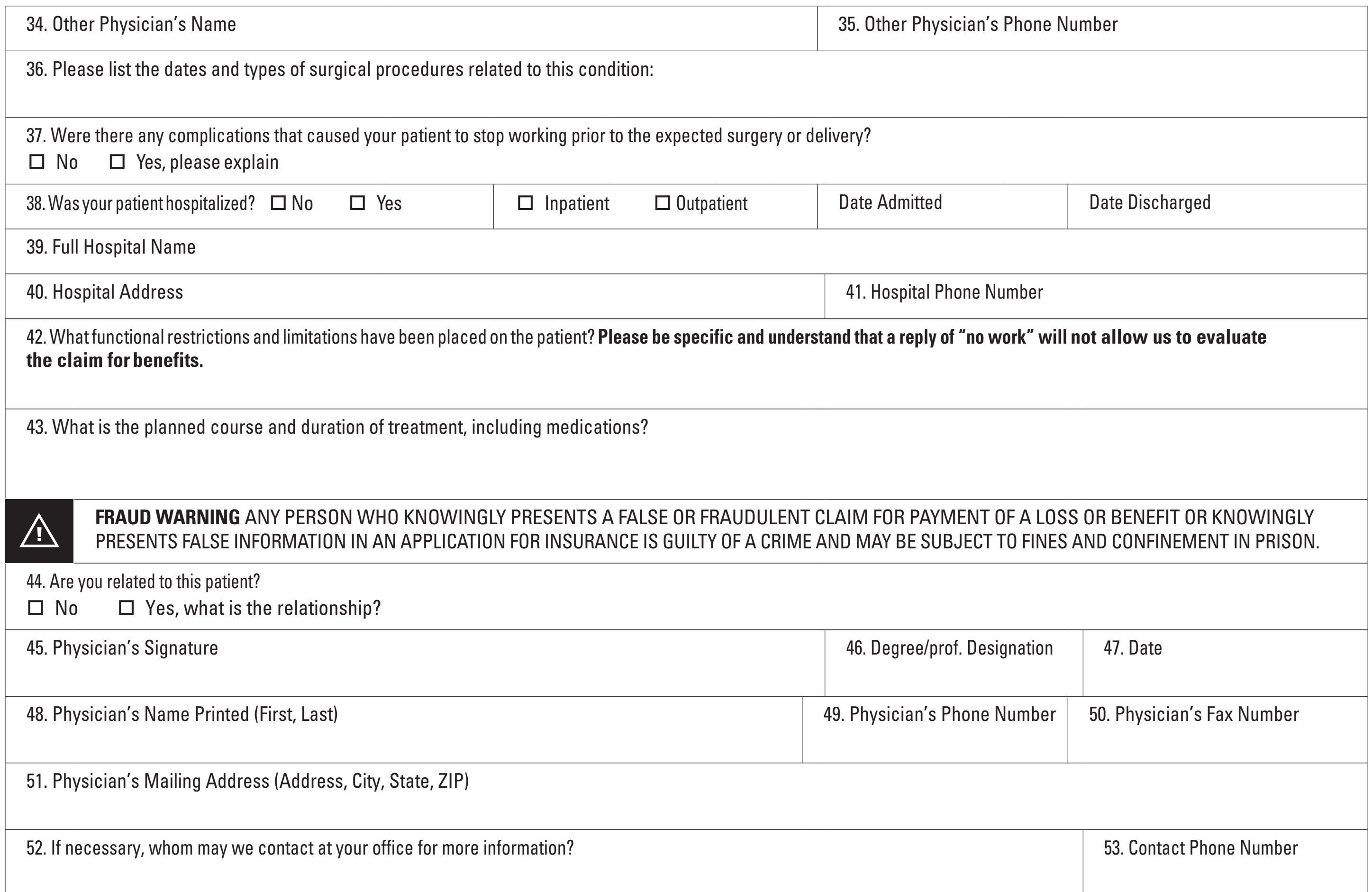
24. What date was the patient first unable to work due to disability?	25. What date did you first discuss the possibility of the patient being unable to continue working due to disability?

26. Please advise if this will be: ☐ Continuous Leave ☐ Reduced Schedule ☐ 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? ☐ No ☐ 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? ☐ No ☐ 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?
☐ No ☐ Yes, please explain

38. Was your patient hospitalized? ☐ No ☐ Yes	☐ Inpatient ☐ 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?
☐ No ☐ 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

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