Long Term Disability Claim Statement

ASSURANT Employee Benefits®

For your protection, the following disclosures are required by state law and are based on the state where you live:

If you live in the states of Alaska or Oregon, the following statement applies to you:
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.

If you live in the states of Arizona or New Jersey, the following statement applies to you:
A person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

If you live in the states of Arkansas, Louisiana, Maryland, or Rhode Island the following statement applies to you:
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.

If you live in the state of California, the following statement applies to you:
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 Colorado, the following statement applies to you:
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 policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder 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.

If you live in Delaware, Florida, Idaho, Indiana or Oklahoma, the following statement applies to you: WARNING: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or application containing any false, incomplete, or misleading information is guilty of a felony. In Florida, it is a felony of the third degree.

If you live in the District of Columbia, Tennessee or Virginia the following statement applies to you:
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.

If you live in New Hampshire, the following statement applies to you:
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.

To avoid unnecessary delays, be sure all parts of the Claim Statement are completed according to the instructions, and DO NOT SEPARATE the pages.

Assurant Employee Benefits is the brand name for insurance products underwritten by Union Security Insurance Company.

Following is the information for claim submission:

Assurant Employee Benefits PO Box 972030 El Paso Texas 79997-2030
• T 800.451.4531 • F 816.556.7687 • KCBenefitCenter@assurant.com

If you live in New York the following statement applies to you:

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 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.

If you live in Minnesota, the following statement applies to you:

A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

If you live in Texas, the following statement applies to you:

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, the following statement applies to you:

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.

Please read the following instructions carefully for proper completion of the attached Long Term Disability Claim Statement. If this is not fully completed, the Claim Statement will be returned for completion.

Do not separate the pages of this Claim Statement. Additional physician's statements may be obtained from your Regional Benefit Center or by copying the physician's statement included in this statement. Attach any additional physician's statements to the Claim Statement.

After the Employer Section has been fully completed, forward the entire statement to the claimant for completion of the Claimant Statement. If the claimant has returned to work or if the claim is for pregnancy, Part 2 of the Claimant's Statement does not need to be completed. After the Employer and Claimant Statements are fully completed, forward the entire statements to the attending physician(s) for completion of the Physician's Statement. This must be the physician(s) who rendered treatment at the onset of this disability.

Instructions for completion of the Employer's sections follow:

Employer Claim Statement—Part 1

Please indicate at the top of the form whether or not this is a new claim.

1.–9. Self-explanatory.

10. Effective date of the claimant's LTD coverage.

11. The last day the claimant actually worked at his/her regular occupation, and the total number of hours worked on his/her last day.

12. The number of days per week and the number of hours per day the claimant was regularly scheduled to work prior to his/her disability.

13. Self-explanatory.

14. This question should be completed if your company had LTD coverage through a different carrier, immediately prior to your Assurant Employee Benefits' coverage. If applicable, provide us with the claimant's effective and termination dates under the **prior plan**.

15. Any other coverages the claimant has with Assurant Employee Benefits. *(i.e., Life, Medical, Dental, etc.)*

16.–17. If the claimant has returned to work, advise us of his/her **current** work schedule.

18. Advise us of the outcome of your discussion(s) with the claimant, and if any reasonable accommodations were able to be made to allow the claimant to return to work.

19. The claimant's basic monthly earnings as of the determination date indicated in your LTD policy. If the claimant receives any bonuses, commissions or other unusual compensation, review the Policy Definition of Monthly Earnings and provide supporting documentation.

20.–22. LTD benefits may be taxable. These questions are essential for us to make that determination.

23. Self-explanatory.

24. For any source of income marked, please attach payroll records, award notices, denial notices or any other available documentation.

25. Self-explanatory.

26. This portion of the claim statement must be signed by someone other than the claimant who is filing this claim. Be sure to indicate the title or position of the person signing this form.

Employer Claim Statement—Part 2

Fully complete this section of the claim statement for **all** claims.

Please attach a copy of the employer's own description of the claimant's position to this claim statement. If a job description is not available, please attach a separate sheet describing the nature and essential duties of the claimant's position. This section should be completed by someone who is familiar with the claimant's position; i.e., supervisor.

<u>Physical Aspects</u>

1. Self-explanatory.

2. Please tell us how often the claimant does each of the activities listed and the amount(s) of weight, if any, the claimant is required to lift and carry in a typical work day.

☐ Never = 0 hours

☐ Occasionally = 1/4–2-1/2 hours

☐ Frequently = 2-1/2–5-1/2 hours

☐ Continuously = 5-1/2 hours or more

3.–5. Self-explanatory.

<u>Stress/Non Physical Aspects</u>

For each question listed, please indicate how often the claimant is involved in these activities, by providing us with the percentage of the work day the claimant spends in each activity.

Long Term Disability Claim Statement

* Required Field

ASSURANT Employee Benefits®

Employer Claim Statement—Part 1 *(Please print or type. If necessary, add separate sheet.)* New claim: ☐Yes ☐No

1. Name of employer	2. Policy no.*	3. Participation no.	4. Account no.

5. Employer's Business Entity Form *(e.g. corporation, professional corporation, professional association, S corporation, partnership, proprietorship)*

6. Does the claimant have an ownership interest in the employer?
☐Yes ☐No If "Yes," ownership percentage _____%

7. Full legal name of claimant*

8. Social Security no.	9. Date employed	10. Effective date of insurance

11. Date last worked _____
No. of hours worked that day _____

12. Work schedule of claimant at time of disability:
_____Days per week _____Hours per day

13. Was claimant a member of a union?
☐Yes
☐No

14. Was claimant covered under your prior LTD plan? ☐Yes ☐No
Effective date under **prior** plan _____
Termination date under **prior** plan _____

15. Does claimant have any other coverage(s) with Assurant Employee Benefits?
☐Yes ☐No If "Yes," please advise of the type of coverage(s).

16. Has claimant returned to work? ☐Yes ☐No
If "Yes," on what date:
_____With restrictions _____Full capacity

17. Current work schedule of claimant?
_____Day(s) per week _____Hours per day

18. a. Have you and the claimant discussed reasonable accommodations which would allow a return to work? ☐Yes ☐No
b. Do you have an established return to work program? ☐Yes ☐No
If "Yes" to either, please explain.

c. What accommodations have you implemented?

19. Basic earnings $_____ per ☐Hourly ☐Weekly ☐Bi-Weekly ☐Monthly ☐Other _____

How is claimant paid? ☐Hourly ☐Salaried ☐Salary + Commission ☐Commission only ☐Salary + Bonus
Effective date of last salary change _____ ☐Other _____

20. Does claimant contribute towards the cost of this LTD insurance? ☐Yes ☐No
If "Yes," ☐Pre-tax ☐Post-tax If "Post-tax," _____% premium dollars paid by employer, _____% paid by claimant

21. Does the employer participate in the Social Security portion of FICA? ☐Yes ☐No
If "Yes," Year-to-date earnings paid to the claimant as of today's date (for FICA determination) $_____

22. Has the claimant's contribution % or the pre/post-tax % changed within the past 4 calendar years? ☐Yes ☐No

23. Did this disability occur as a result of the claimant's employment? ☐Yes ☐No ☐Currently disputed
If "Yes," or under dispute, please provide us with the policy no., name, address and phone no. of Workers' Compensation administrator.

24. To the best of your knowledge, is the claimant receiving, or entitled to receive benefits from any of the following sources?

☐Salary continuance	Amount: _____ per _____	From _____ to _____
☐Workers' Compensation	Weekly benefit _____	Effective date _____
☐Retirement or pension	Benefit amount _____	Effective date _____
☐National Guard/Military Reserve Pay		
☐Other _____	Lump sum distribution? ☐Yes ☐No	

25. Do you wish to have disability checks sent directly to claimant's home? ☐Yes ☐No

26. Date _____ By _____
AUTHORIZED BY (*PLEASE PRINT*)

Fax no. _____ By _____
AUTHORIZED SIGNATURE/TITLE

Phone no. _____ E-mail address _____

DO NOT SEPARATE

Employer Claim Statement—Part 2
Physical/Non Physical Aspects of Job

Please complete this section of the claim statement to provide us with information concerning the physical/non physical demands of claimant's job. Attach a narrative job description if available.

Claimant's Job Title _____

Signature/Title _____ Date _____

STAPLE YOUR OWN JOB DESCRIPTION HERE

Physical Requirements

1. In a typical work day, give the number of hours the claimant spends in each of these positions and if claimant may alternate positions:

Position	Total No. of Hours	May Alternate Positions: At Will	15–30 Minutes	Hourly	Never
Sitting	_____	☐	☐	☐	☐
Standing	_____	☐	☐	☐	☐
Walking	_____	☐	☐	☐	☐
Driving	_____	☐	☐	☐	☐

2.

Claimant must	Never	Occasionally (1/4–2 1/2 hours)	Frequently (2 1/2–5 1/2 hours)	Continuously (5 1/2–8 hours)
A. Bend/Stoop	☐	☐	☐	☐
B. Climb	☐	☐	☐	☐
C. Reach above shoulder level	☐	☐	☐	☐
D. Kneel	☐	☐	☐	☐
E. Balance	☐	☐	☐	☐
F. Enter data/keystroke	☐	☐	☐	☐
G. Squat	☐	☐	☐	☐
H. Crawl	☐	☐	☐	☐
I. Crouch	☐	☐	☐	☐
J. Lift: Usual _____ lbs.	☐	☐	☐	☐
Max _____ lbs.	☐	☐	☐	☐
K. Carry Usual _____ lbs.	☐	☐	☐	☐
Max _____ lbs.	☐	☐	☐	☐
L. Push/Pull Usual _____ lbs.	☐	☐	☐	☐
Max _____ lbs.	☐	☐	☐	☐

3. On the job, claimant uses feet for repetitive movements as in operating foot controls.
   Right: ☐Yes ☐No Left: ☐Yes ☐No Both: ☐Yes ☐No

4. On the job, claimant uses hands for repetitive action such as:

	Simple Grasping	Firm Grasping	Fine Manipulation
A.Right	☐	☐	☐
B. Left	☐	☐	☐

5. Does job require:
   A. Working at unguarded heights? ☐Yes ☐No
   B. Exposure to marked changes in temperature and humidity or extremes thereof? ☐Yes ☐No
   C. Exposure to dust, fumes, gases, chemicals? ☐Yes ☐No

Stress/Non Physical

1. Percentage of time claimant spends answering customer complaints. _____%
2. Percentage of claimant's work primarily judged on production. _____%
3. Does this claimant depend upon the assistance of others in order to accomplish his/her daily tasks?
   ☐Yes ☐No _____% of time
4. How many employees does this claimant supervise? _____
5. Is this claimant routinely subject to close supervision? ☐Yes ☐No
6. Percentage of time spent by the claimant working with his/her co-workers. _____%
7. Percentage of claimant's time spent on: _____% Prescheduled activities
   _____% Random activities
8. Percentage of time claimant spends meeting deadlines set by others. _____%
9. Percentage of responsibility the claimant has for the performance of his/her particular department. _____%

DO NOT SEPARATE

Claimant Statement—Part 1 *(Please print or type.)* **Complete Part 1, Part 2, and Authorizations on pages 8 and 9.**

Section I Attach additional pages if needed

1. Full name *(as it appears on your Social Security card)*	2. Social Security no.	3. Date of birth	4. Home phone no.
5. Address *(street, city, state, zip code)*	6. Sex: ☐Male ☐Female	7. E-mail address	
8. Marital status: ☐Single ☐Married ☐Widowed ☐Divorced	9. Your job title	10. Cell phone no.	
11. Names and birthdates of spouse and all dependent children under age 18.			

Section II

1. Nature of illness and when symptoms first appeared, or describe how and where accident occurred. If motor vehicle accident, in what state did accident occur? _____	2. Date first unable to work because of this disability.

3. Have you returned to work? ☐Yes ☐No If "Yes," on what date: _____ Part-time _____ Full-time

If you have not returned to work, on what date do you expect to return to work? _____ Part-time _____ Full-time

4. Please provide the names and addresses of all physicians who have been consulted for this condition. Please include dates of consultation.

Name | Address (*city, state)* | Phone no. | First Visit | Last Visit

5. If you have been hospital confined for this disability, please provide name and address of hospital and confinement dates.

Name of Hospital | Address | From | To

6. Please provide name, address and phone number of your pharmacy.

Section III

1. Check if you are receiving or entitled to receive benefits from any of the following sources:

☐Salary, Wages or Commissions ☐Retirement or Pension Plan ☐Railroad Retirement Act
☐State Disability ☐Social Security Disability ☐National Guard/Military Reserve
☐Workers' Compensation ☐Social Security Retirement ☐Other sources

For each source marked above, please provide us with the following information:

Source	Amount of Income Amount	Frequency	Date Application Filed	Benefit Effective Date

Provide documentation of any source indicated above; i.e., award notices, denial notices or applications.

2. Do you have medical insurance? ☐Yes ☐No Policy no., name, address and phone no. of medical plan administrator.

Please indicate the type of coverage provided ☐COBRA ☐Other *(Specify.)* _____

DO NOT SEPARATE

Claimant Statement—Part 2 *(Do not complete this section if you have returned to work, or if disability is for pregnancy.)*

Training, Education & Experience

1. What is your highest level of education?

☐less than 9 College ☐1 Degree earned _____ Date _____
☐9–11 ☐2
☐High School/GED ☐3 Major field of study _____
☐4
☐Post graduate

Trade school/additional education

Type of training _____

Date of certification/diploma _____

Date last attended _____

Do you have any computer skills? ☐Word Processing ☐Spreadsheet ☐Graphics ☐ Internet

2. Please list all previous occupations and the dates worked for each occupation. Please attach a copy of your resume, if available.

3. Do you have an ownership interest in your employer? ☐Yes ☐No Ownership percentage _____%

4. What were your job duties when disability commenced?

5. How does your sickness or injury prevent you from performing your duties listed above?

6. Have you discussed returning to work or commencing a vocational rehabilitation program with your doctor?
☐Yes ☐No

7. Have you asked your employer to provide any accommodations which would allow you to return to work?
☐Yes If "Yes," what accommodations did you request and what was your employer's response?

☐No If "No," what accommodations do you feel could be made by your employer to allow you to return to work?

8. Have you considered retraining? ☐Yes ☐No If "Yes," what vocational area(s) would interest you?

9. Please list any hobbies, outside interests or activities.

10. If you are receiving Workers' Compensation benefits, have you been contacted by the Workers' Compensation carrier regarding vocational rehabilitation? ☐Yes ☐No

If "Yes," what is the name, address and phone number of the counselor handling your case?

11. Have you contacted your state Division of Vocational Rehabilitation Department? ☐Yes ☐No

If "Yes," what is the name, address and phone number of the counselor handling your case?

12. Would you like Assurant Employee Benefits' Vocational Rehabilitation Department to contact you to discuss options available which may assist you in returning to gainful employment? ☐Yes ☐No

STAPLE RESUME, IF AVAILABLE

DO NOT SEPARATE

I authorize any provider of medical services, insurance company, consumer reporting agency, Social Security Administration, governmental agency, educational institute, law enforcement agency, or employer having medical information with respect to any physical or mental condition, rehabilitation and other non-medical information of me to give to Union Security Insurance Company, or its representative, any and all such information. I understand Union Security Insurance Company may discuss my limitations/restrictions with treating physicians and current or prospective employers as they relate to accommodations and possible return to work. **I UNDERSTAND** the information obtained by use of this Authorization will be used by Union Security Insurance Company to determine the eligibility for benefits. I know that a photographic copy of this authorization shall be as valid as the original. I agree this Authorization shall be valid for the duration of the claim. This authorization is not governed by HIPAA, however, when necessary, I may be asked to execute a HIPAA authorization form, allowing Union Security Insurance Company to use and disclose protected health information.

If I receive a disability benefit greater than that which I should have been paid, I understand this insurance company has the right to recover such overpayments from me, including the rights to reduce or adjust future benefits, if any.

Signature of claimant _____ Date _____

DISABILITY - HIPAA Authorization For Release of Protected Health Information

ASSURANT Employee Benefits®

Insured/Member name _____ SSN _____ DOB _____

Address _____ City _____ State _____ Zip _____

Policy no. _____ Participation no. _____ Account no. _____ Certificate no. _____

Persons/categories of persons providing the information: Any provider of health care services; hospital, clinic, other medical or medically related facility; insurance or reinsuring company; pharmacist, pharmacy benefits manager, or pharmacy-related services entity; federal, state or local government agency including the Social Security Administration; consumer reporting agency; educational institute; vocational provider; accountant or tax preparer; or employer.

Persons/categories of persons receiving the information: Union Security Insurance Company or Union Security Life Insurance Company of New York ("Companies").

I hereby authorize the use or disclosure of my information as described below:

Information to be disclosed: All medical and non-medical information necessary to allow the Companies or its representatives to determine my eligibility for benefits and to process my claim. Such information may include, but is not limited to: records about my physical and mental health, including diagnosis or treatment for Human Immunodeficiency Virus (HIV), AIDS or other immune disorders, sexually transmitted diseases, use of alcohol and/or drugs; pharmacy records; records regarding Social Security benefits, Worker's Compensation and other insurance claims and benefits, State Disability benefits, and pension benefits; earnings records; tax records and/or records regarding my employment history.

I understand the following:

- The information obtained by use of this authorization will be used by the Companies to evaluate and adjudicate my current disability claim, and may be re-disclosed to the Companies' reinsurer(s). The Companies may release information to my treating physician and current or prospective employers relating to restrictions, accommodations and possible return to work. The information may also be released to (a) any medical, investigative, financial, vocational, or other organization or person, employed by or representing the Companies with the evaluation and adjudication of my current disability claim, (b) a Social Security vendor that may assist me in filing a claim with the Social Security Administration, and (c) other insurance companies or their representatives to help investigate and adjudicate other insurance claims related to me.
- I have the right to refuse to sign this authorization; however, if I refuse to sign this authorization, I understand that the Companies may not be able to gather the information necessary to determine if I am eligible for coverage or benefits under one of the Companies' insurance policies. I understand that a photocopy or facsimile of this authorization is as valid as the original. Upon request, I may receive a copy of this authorization.
- This authorization is voluntary. I may revoke it at any time by writing Assurant Employee Benefits, Privacy Office, PO Box 419052, Kansas City, MO 64141-6052. Any such revocation will not affect any actions that Companies took before receipt of the revocation.
- Federal law requires that we inform you that the information that we collect may, under certain circumstances, be re-disclosed by us to third parties and thus no longer protected by federal law.
- I understand that any information obtained by this authorization may be used and disclosed by HIPAA and non-HIPAA plans

This authorization is effective from the date signed below until my claim ends.

_____ _____

SIGNATURE OF INSURED/MEMBER OR LEGAL PERSONAL REPRESENTATIVE — DATE

_____ _____

PRINTED NAME OF LEGAL PERSONAL REPRESENTATIVE — RELATIONSHIP TO INSURED/MEMBER

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

Assurant Employee Benefits is the brand name for insurance products underwritten and services provided by Union Security Insurance Company.

Attending Physician's Initial Statement of Disability

ASSURANT Employee Benefits®

The patient must pay any costs for completion of this form.

To the Attending Physician

Please read the following instructions before completing this form. **Do not separate the pages of this claim statement.**

Authorizations to release information can be found on pages 8 and 9.

Clearly print or type this form. Fully complete each applicable section of this form. Review the attached Job Description and Training, Education and Experience sections before completing the last page of this form. The Job Description is Part 2 of the Employer's Claim Statement, and the Training, Education and Experience section is Part 2 of the Claimant's Statement.

Sign and date this form after completion. Also, clearly print or type your name, address and phone number in the spaces provided. If applicable, include your fax number.

After you have completed this form, return the entire claim statement to the patient.

Name of patient	Date of birth	Social Security number

History

Patient's symptoms result from *(Check all that apply.)*: ☐Employment ☐Illness ☐Accident ☐Motor Vehicle Accident ☐Pregnancy

If pregnancy, *(expected/actual delivery date)* _____ Type of delivery _____

Date symptoms first appeared _____ Patient's height _____ Weight _____

Name(s), address(es), specialty(ies) of other treating or referring physician(s)

First visit for this condition _____ Most recent visit _____ Most recent comprehensive exam _____

Hospital name _____ Confinement dates _____ thru _____

Diagnoses

Diagnoses with ICD9-CM codes: list in desending order of severity (including complications). Please go to the appropriate assessment section and elaborate. ICD9 _____ _____ _____ _____

Subjective symptoms

Objective findings

Attach medical records which document the above diagnostics. *(Include results/copies of x-rays, lab tests, EKGs, MRIs and scans)*

Do you believe a legal guardian or conservator should be appointed for this patient? ☐Yes ☐No

Functional Assessment

In terms of an 8 hour day:

☐Class 1—No limitation; capable of heavy work*—exert 50–100# force occasionally and/or 25–50# force frequently.

☐Class 2—Medium activity*—exert occasional 20–50# force and/or 10–25# force frequently.

☐Class 3—Slight limitation; capable of light work*—exert occasional 20# force and/or up to 10# force frequently.

☐Class 4—Moderate limitation; capable of sedentary*, clerical or administrative work—occasional 10# force, mostly sitting.

☐Class 5—Severe limitation; incapable of minimal activity or sedentary* work. ☐Bed confined ☐House confined

*As defined by the U.S. Department of Labor's Federal Dictionary of Occupational Titles

Please fully describe the patient's capabilities: *With allowance for positional change.

N=Never **O**=Occasionally (1/4–2 1/2 hours) **F**=Frequently (2 1/2–5 1/2 hours) **C**=Continuously (5 1/2–8 hours)

_____ Standing* _____ Sitting* _____ Walking* _____ Driving* _____ Bending* _____ Data Entry*

Lifting not more than _____ pounds _____(how often) Carry not more than _____ pounds _____ (how often)

When did these capabilities begin? _____

Do you anticipate an increase in your patient's functional capabilities? If so, what date _____

DO NOT SEPARATE

Treatment

Describe treatment program and give dates of any surgery, medications (dosages/administration routine), physical therapy or psychotherapy.

Frequency of treatment and/or symptoms: ☐Weekly ☐Monthly ☐Other *(Specify.)* _____

Next scheduled visit _____

Cardiac

Complete only if applicable.

Functional capacity (American Heart Association)

☐Class 1 *(no limitation)* ☐Class 2 *(slight limitation)* ☐Class 3 *(marked limitation)* ☐Class 4 *(complete limitation)*

Blood pressure (latest reading) _____ as of (date) _____

METS level _____ Date _____ Ejection fraction _____ % Date _____

Is patient in a cardiac rehabilitation program? ☐Yes ☐No

If "Yes," please include dates. Start _____ End _____

Psychiatric Assessment

List the patient's DSM Code(s): _____

Description _____

Please define stress as it applies to this patient.

What stress and problems in interpersonal relations has patient had on the job?

Please fully describe the patient's limitations.

When did these limitations apply?

Began _____ Anticipated reduction _____ Anticipated end date _____

Do you believe a legal guardian or conservator should be appointed for this patient? ☐ Yes ☐ No

Rehab

Is patient a candidate for vocational rehabilitation services? ☐Yes *(Describe.)* ☐No *(Explain.)*

Describe any job modifications that would aid your patient in performing his/her work tasks.

Has patient reached maximum medical improvement? ☐Yes ☐No If "No," when? _____ ☐Unknown

Name

Physician's name _____ Degree _____ Specialty/Board certification _____

Address _____
STREET CITY STATE ZIP CODE

Telephone no. _____ Fax no. _____

Signature _____ Date _____
DO NOT PRE-DATE

DO NOT SEPARATE