CONTINENTAL AMERICAN INSURANCE
Post Office Box 84075 * Columbus, GA. 31993
Phone (800) 433-3036 * Fax (866) 849-2970
groupclaimfiling@aflac.com

ACCELERATED DEATH BENEFIT CLAIM FORM INSTRUCTIONS

To avoid delays in processing of your claim form, complete each section attaching documentation below when it applies.

Supporting Documentation Needed

Physician's information and signatures

Attach medical records pertaining to diagnosis

Sign and return attached Authorization to Obtain Information form.

Email form to groupclaimfiling@aflac.com or fax to 1.866.849.2970.

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ACCELERATED DEATH BENEFIT CLAIM FORM

SECTION A – INSURED'S INFORMATION		
Name:	Policy/Certificate#:	
Date of Birth:	Social Security Number:	Phone: ☐ Cell ☐ Home ☐ Work
Address:	Email Address:	
Occupation:	Current Illness:	
Date of Diagnosis:	Payment Type: ☐ Lump Sum ☐ Periodic	

SECTION B – ATTENDING PHYSICIAN'S STATEMENT (To be completed by the attending physician)		
Name of Patient:	Patient ID Number:	
Please State the Diagnosis:	ICD-10 Code:	
Describe the nature and cause of the injury or condition:		
Date Symptoms first occurred:	Has the condition persisted for at least 90 days? ☐ Yes ☐ No	
Has the patient had the same or similar condition? ☐ Yes ☐ No	If no, what are the contributing factors?	
List all dates of treatment:		
Is patient hospitalized? ☐ Yes ☐ No	If yes, give dates:	

Hospital Name (s):	**Address**	**City, State, Zip**	**Phone**
Name of Referring Physician (if applicable):	**Address**	**City, State, Zip**	**Phone**

Prognosis	
Do you conclude the patient is terminally ill? ☐ Yes ☐ No	If Yes, what is their life expectancy in number of months:

Which Activities of Daily Living is the patient unable to perform:

- ☐ Bathing: Washing oneself by sponges bath or in either a tub or shower, including the task of getting into or out of the tub or shower.
- ☐ Maintaining continence: Controlling urination and bowel movements, including the Named Insured's ability to use ostomy supplies or other devices such as catheters.
- ☐ Transferring: Moving between a bed and a chair, or a bed and a wheelchair.
- ☐ Dressing: Putting on and taking off all necessary items of clothing
- ☐ Toileting: Getting to and from a toilet, getting on and off a toilet, and performing associated personal hygiene.
- ☐ Eating: Performing all major tasks of getting food into the Named Insured's body.

Physician Information			
Physician's Name (Please Print):		Specialty:	
Address:	City, State, Zip:	Phone:	Fax:
Physician's Signature:			Date:

Authorization

<u>Disclosure Authorization</u> The following disclosure is made pursuant to the Fair Credit Reporting Act:

Please be notified that, as a result of our regular claims investigation procedures, an investigative consumer report may be prepared, whereby information received from third parties is obtained from an independent inspection company. You have the right to make a written request within a reasonable period of time to receive detailed information about the nature and scope of this investigation.

Authorization:

I authorize any physician, medical practitioner, hospital, clinic or other medical or medically related facility, Veterans Administration or government agency to furnish all information and copies of records regarding health care or treatment provided me, including but not limited to, admitting records, hospital records, test records, findings and diagnostics. Such information and records shall be provided to a representative of the Claims Department of Aflac. Information obtained by this authorization is for use solely to determine my eligibility of insurance benefits. This authorization includes information about drugs, alcoholism or mental illness.

I authorize my present or past employers (s) to supply information covering the status of my employment, job duties, days absent from work and training provided. This information may be provided to a representative of Aflac and is to be used solely to determine my eligibility of insurance benefits. Any information obtained will not be released by Aflac to any person or organization.

I further authorize Aflac to release all copies of medical records collected during its investigation to a second physician (and third, if required). I further authorize this statement to be copied and the copy utilized as if it were an original. I understand that upon request I have a right to obtain a copy of this authorization. I understand this authorization will remain valid for one year from the date of signature.

I understand failure to sign this authorization may delay payment of benefits.

Owner's signature:_____ Date:_____

SIGNATURES REQUIRED:

I have read the statement on this form and concur with them. I am of sound mind and have advised my beneficiaries, the executor of my estate, and my attorney of my action and have instructed that I alone am responsible for seeking this benefit. If the Accelerated Death Benefit is advanced to me, my executor, assignees, beneficiaries and I agree to hold Aflac harmless and free from all liability for having advanced this death benefit.

Insured/Claimant signature: _____ Date:_____

Spouse signature: _____ Date:_____
(If a Community Property state, I hereby forever waive all community property right and claims to any funds paid pursuant to the Accelerated Death Benefit and agree that said check should be made payable to the owner).

Owner signature: _____ Date:_____
(If other than insured)

Irrevocable Beneficiary signature: _____ Date:_____
(If applicable, I hereby forever waive all rights and claims to any funds paid pursuant to the Accelerated Death Benefit and agree that said check should be made payable to the owner.)

Notarized signature _____ Date:_____

INSURED STATEMENT OF CLAIM-COMMUNICATION
THIRD PARTY COMMUNICATION AUTHORIZATION Complete this authorization if you would like us to discuss, to release or to provide information to a family member, friend or other third party such as your agent or employer.
My Spouse or Partner (Name): ☐ All Information (All policy and claim information) ☐ All information ***EXCEPT*** Medical Information (diagnosis, medical condition, reason for claim, treatment, physicians)
My Family Member (Name and Relationship): ☐ All Information (All policy and claim information) ☐ All information ***EXCEPT*** Medical Information (diagnosis, medical condition, reason for claim, treatment, physicians)
Other Third Party: ☐ My Agent (Name):_____ ☐ My Employer (Name): _____ ☐ Other Third Party (Name and Relationship): _____ ☐ All information (All policy and claim information) ☐ All information ***EXCEPT*** Medical Information (diagnosis, medical condition, reason for claim, treatment, physicians)
I agree that if I authorize release of all claim information this may include health information which may be related to disorders of the immune system including but not limited to HIV and AIDS, use of alcohol or drugs, mental and physical condition, history or treatment. I understand that any information shared may be subject to re-disclosure and might not be protected by certain federal regulations governing the privacy of health information relative to my condition.
AUTHORIZATION
I may revoke or update this authorization in writing at any time or by email to groupclaimfiling@aflac.com. Aflac may rely on this information I provide for the adjudication of my claim as a result of this authorization until receipt of my revocation notice. This authorization is valid for two (2) years. I may request a copy of this authorization and a copy is valid as the original. Policy Owner Signature: _____ Date:_____ Printed Name:_____ Social Security Number:_____

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AUTHORIZATION TO OBTAIN INFORMATION

MAIL TO: Continental American Insurance Company
P.O. Box 84075
Columbus, Georgia 31993

CALL: 1.800.433.3036 (toll-free)
CLAIM FAX: 1.866.849.2970

Primary Certificateholder's Name:	**SSN**(optional):	**Date of Birth:**
Certificate Number(s):		
Address:		
Name of Individual Subject to Disclosure (If not the primary Certificateholder):		**Date of Birth:**
Relationship to Primary Certificateholder: ☐ Self ☐ Spouse ☐ Domestic Partner ☐ Child ☐ Stepchild ☐ Grandchild		

I. Authorization:
For the purpose of evaluating my *eligibility for insurance and for benefits* under an existing certificate, including checking for and resolving any issues that may arise regarding incomplete or incorrect information on my application for coverage and/or claim form, I hereby authorize the disclosure of the following information(defined below) about me and, if applicable, my dependents, from the sources listed below to Continental American Insurance Company (CAIC), or any person or entity acting on its part, to include American Family Life Assurance Company of Columbus and American Family Life Assurance Company of New York (collectively, "Aflac).

II. Disclosure of Health Information:
Health information may be disclosed by any health care provider, health plan (including CAIC or Aflac, with respect to other CAIC or Aflac coverages) or health care clearinghouse that has any records or knowledge about me. Health care provider includes, but is not limited to, any licensed physician, medical or nurse practitioner, nurse, pharmacist, osteopath, psychologist, physical or occupational therapist, chiropractor, dentist, audiologist or speech pathologist, podiatrist, hospital, medical clinic or laboratory, pharmacy, rehabilitation facility, nursing home or extended care facility, prescription drug database or pharmacy benefit manager, or ambulance or other medical transport service. Health information may also be disclosed by any insurance company or the Medical Information Bureau (MIB). Health information includes my entire medical record, but does not include psychotherapy notes. Some information obtained may not be protected by certain federal regulations governing the privacy of health information, but the information is protected by state privacy laws and other applicable laws. CAIC will not disclose the information unless permitted or required by those laws.

III. Rights and Expiration:
I understand that I may revoke this authorization at any time, except to the extent that CAIC or Aflac has taken action in reliance on this authorization. If I revoke this authorization, CAIC may not be able to evaluate my application for coverage and/or claim. To revoke this authorization, I must provide a written and signed revocation to CAIC at the address or fax number above. Unless otherwise revoked, this authorization shall remain in effect for two (2) years from the date signed or upon my death, whichever occurs first. I agree that a copy of this authorization is as valid as the original and that I or an authorized representative may request a copy of this authorization.

IV. Notice:
I understand that CAIC is not conditioning payment, enrollment, or eligibility for benefits on whether I sign this authorization. I understand that if the information disclosed is protected health information relating to a health plan and the person or entity receiving the information is a not a health care provider or health plan covered by federal privacy regulations, the information disclosed may be redisclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

- **If records are on an adult dependent, (e.g. spouse, child over 18), the dependent must sign this form**
- **If records are on a minor child the natural parent or legal guardian must sign on their behalf.**

_____ _____
Signature of Individual Subject to Disclosure Date Signed

_____ _____ _____ _____
Legal Representative's Printed Name Legal Representative's Signature Legal Relationship Date Signed

If signed by a legal representative (e.g. Legal Guardian, Estate Administrator, Power of Attorney)

FRAUD WARNING NOTICES

For use with Claim Forms

PLEASE READ THE FRAUD WARNING NOTICE FOR YOUR STATE

ALASKA: A person who knowingly and with intent to injury, defraud or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.	**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.
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.	**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.
ARKANSAS: 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.	**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.
CALIFORNIA: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.	**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.
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.	**MAINE:** 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. **MARYLAND:** Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
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.	**MINNESOTA:** A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilt of a crime.
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.	**NEW HAMPSHIRE:** Any person who, with a purpose toinjure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, ormisleading information is subject to prosecution andpunishment for insurance fraud, as provided in RSA638:20.
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.	**NEW JERSEY:** Any person who knowingly files astatement of claim containing any false or misleading information is subject to criminal and civil penalties.

FRAUD WARNING NOTICES (CONT.)

For use with Claim Forms

PLEASE READ THE FRAUD WARNING NOTICE FOR YOUR STATE

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.	**TENNESSEE:** 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.
NEW YORK: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.	**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.
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.	**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 denial of insurance benefits.
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.	**WASHINGTON:** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.
OREGON: 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 may be guilty of insurance fraud.	**RHODE ISLAND and WEST VIRGINIA:** 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.
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.	**ALL OTHER STATES:** 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.
PUERTO RICO: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars($5,000) and not more than ten thousand dollars($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.	

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BENEFICIARY'S STATEMENT

Failure to complete all sections may result in a delay in processing of the claim.

Any person who knowingly and with the intent to defraud any insurance company, files a statement of claim containing any materially false, incomplete or misleading information, is guilty of a crime.

AUTHORIZATION: I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medically related facility, insurance company or consumer reporting agency, or employer having any records or information pertaining to the medical history, mental or physical condition, evaluation diagnosis, treatment, prognosis, specifically to include psychiatric, drug or alcohol abuse treatment concerning the deceased and any other non-medical information concerning the deceased to give to Continental American Insurance Company (Continental American) or its legal representatives, any or all such information. I further acknowledge that the information obtained by use of this Authorization will be used by Continental American to determine my eligibility for benefits. I understand that I may request a copy of this authorization. I further agree that a photocopy of this Authorization shall be as valid as the original and that such Authorization shall be valid for two years from the date shown below.

Dated at _____ this _____ day of _____ in the year _____

Certificate Holder/Beneficiary Signature

POLICYHOLDER/PATIENT INFORMATION				
EMPLOYER'S NAME		POLICYHOLDER'S ADDRESS		
POLICYHOLDER'S NAME	POLICY NO.	SOCIAL SECURITY NO.	DATE OF BIRTH	GENDER
POLICYHOLDER'S ADDRESS CITY STATE ZIP ☐ CHECK BOX IF THIS IS A PERMANENT ADDRESS CHANGE			POLICYHOLDER'S TELEPHONE NO.	
PATIENT'S NAME	RELATIONSHIP TO POLICYHOLDER	PATIENT'S DATE OF BIRTH	PATIENT'S GENDER	

DECEDENT'S INFORMATION			
Deceased's Name in Full	Date of Birth	Place of Birth	
Resident's Address			Social Security Number
Certificate numbers of this company and amounts under which claim is being filed	Certificate numbers, amounts and company name of other insurance being claimed.		

PRINTED BENEFICIARY NAME	BENEFICIARY ADDRESS	RELATIONSHIP TO THE INSURED	DATE OF BIRTH	PHONE NUMBER

BENEFICIARY'S STATEMENT

A Beneficiary's Statement must be completed. In connection with such statement, the following should be observed:

1. If there is more than one beneficiary, all may join in one statement or a separate form will be furnished for each if desired.
2. If the policy is payable to the estate or to the executors or administrators of the insured, the statement should be completed by the executor or administrator, a certified copy of whose appointment and qualifications must be furnished.
3. If the policy is payable to a minor or a mentally incompetent person, a guardian should complete the statement, a certified copy of whose appointment and qualifications must be provided.
4. If the policy has been assigned, enclose a notarized copy of the assignment.

To prevent delays, please complete the remaining sections and submit the following information:

- A certified copy of the decedent's birth certificate or a notarized letter verifying the decedent's date of birth.
- HIPAA Authorization (attached) - This form should be completed by the deceased's next of kin.
- Certified Death Certificate

Under the following circumstances, please send the additional items listed:

- If a minor is the beneficiary- A copy of the court order or other documents appointing the legal custodian or conservator of such minor child's property and/or estate. *(Please note: Legal custody does not qualify as custodianship or conservatorship over a child's property for these purposes.)*
- If the beneficiary has died prior to the death of insured- A copy of the certified death certificate of the beneficiary.

- Date of death: _____
- Place of death: _____
- Cause of death: _____
- If death was due to an injury, please send a copy of the police report, toxicology/BAC report and/or newspaper articles concerning the circumstances and answer the following questions.
    - Date of the injury: _____
    - Details of the injury: _____

- If death was due to a sickness, please answer the following questions.
    - When did the deceased first experience symptoms? _____
    - When did the deceased first consult a physician for this illness? _____

- Please provide the name and addresses of all physicians who attended deceased within three years prior to death:

Name	Address	Dates of Treatment	Disease or Condition

- Was deceased disabled at the time of death? ☐ No ☐Yes
-
    - If yes, as of what date did they become disabled?

- Has the deceased at any time been confined to a hospital? ☐ No ☐ Yes

    - If yes, please provide the hospital name and location along with the dates of confinement and condition treated:

Name	Address	Dates of Treatment	Disease or Condition

AUTHORIZATION TO OBTAIN INFORMAT

Send to:
Continental American Insurance Company
Post Office Box 84075
Columbus, GA 31993

Phone: (800) 433-3036
Fax: (866) 849-2970
Email: groupclaimfiling@aflac.com

Primary Certificate Holder Name:	**SSN**(optional):	**Date of Birth:**	
CertificateNumber(s):			
Address:	**City:**	**State:**	**Zip:**
Name of Individual Subject to Disclosure (If not the primary Certificate Holder):		**Date of Birth:**	
Relationship to Primary Certificate Holder: ☐ Self ☐ Spouse ☐ Domestic Partner ☐ Child ☐ Stepchild ☐ Grandchild			

I. Authorization:

For the purpose of evaluating my *eligibility for insurance and for benefits* under an existing certificate, including checking for and resolving any issues that may arise regarding incomplete or incorrect information on my application for coverage and/or claim form, I hereby authorize the disclosure of the following information(defined below) about me and, if applicable, my dependents, from the sources listed below to Continental American Insurance Company (CAIC), or any person or entity acting on its part, to include American Family Life Assurance Company of Columbus and American Family Life Assurance Company of New York (collectively, "Aflac).

II. Disclosure of HealthInformation:

Health information may be disclosed by any health care provider, health plan (including CAIC or Aflac, with respect to other CAIC or Aflac coverages) or health care clearinghouse that has any records or knowledge about me. Health care provider includes, but is not limited to, any licensed physician, medical or nurse practitioner, nurse, pharmacist, osteopath, psychologist, physical or occupational therapist, chiropractor, dentist, audiologist or speech pathologist, podiatrist, hospital, medical clinic or laboratory, pharmacy, rehabilitation facility, nursing home or extended care facility, prescription drug database or pharmacy benefit manager, or ambulance or other medical transport service. Health information may also be disclosed by any insurance company or the Medical Information Bureau (MIB). Health information includes my entire medical record, but does not include psychotherapy notes. Some information obtained may not be protected by certain federal regulations governing the privacy of health information, but the information is protected by state privacy laws and other applicable laws. CAIC will not disclose the information unless permitted or required by those laws.

III. Rights and Expiration:

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IV. Notice:

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- **If records are on an adult dependent, (e.g. spouse, child over 18), the dependent must sign this form**
- **If records are on a minor child the natural parent or legal guardian must sign on their behalf.**

Signature of Individual Subject to Disclosure Date Signed

Legal Representative's Printed Name Legal Representative's Signature Legal Relationship Date

******If signed by a legal representative (e.g. Legal Guardian, Estate Administrator, Power of Attorney***

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ARKANSAS: 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.	**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.
CALIFORNIA: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.	**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.
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 insuranceand 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.	**MAINE:** 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. **MARYLAND:** Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
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.	**MINNESOTA:** A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilt of a crime.
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.	**NEW HAMPSHIRE:** Any person who, with a purpose toinjure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, ormisleading information is subject to prosecution andpunishment for insurance fraud, as provided in RSA638:20.
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.	**NEW JERSEY:** Any person who knowingly files astatement of claim containing any false or misleading information is subject to criminal and civil penalties.

FRAUD WARNING NOTICES (CONT.)

For use with Claim Forms

PLEASE READ THE FRAUD WARNING NOTICE FOR YOUR STATE

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.

NEW YORK: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

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.

OREGON: 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 may be guilty of insurance fraud.

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.

PUERTO RICO: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuatingcircumstances are present, it may be reduced to a minimum of two (2) years.

TENNESSEE: 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.

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 instate prison.

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 denial of insurance benefits.

WASHINGTON: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

RHODE ISLAND and WEST VIRGINIA: 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.

ALL OTHER STATES: 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.

Life Waiver of Premium Claim For Group Insurance

EB-LWOP-CLAIM (01/17)

LIFE WAIVER OF PREMIUM CLAIM
FILING INSTRUCTIONS

HAVE YOU…

1. Completed the **Employee's Statement** in full?

2. Had the physician treating you complete the **Attending Physician's Statement**, and had it returned to you?

3. Had your Employer complete the **Employer's Statement**, and had it returned to you?

4. Read, signed and dated the **Authorization for Release of Information?**

You are responsible for ensuring all forms are completed and submitted to our office.

Forms can be sent to our Claims Team via:

Email: Aflacclaims@disabilityrms.com

Fax: 1 (866) 376-9480

Regular Mail: Aflac Claims
300 Southborough Drive
Suite 200
South Portland, ME 04106

If you have any questions, please call our Claims Team at 1 (888) 862-5732.

Aflac

Employee Name: _____
Employer Name: _____
Group Number: _____

Fax 1 (866) 376-9480
Toll Free Phone 1 (888) 862-5732

NOTICE OF CLAIM FOR LIFE WAIVER OF PREMIUM BENEFITS

EMPLOYEE'S STATEMENT

(To be completed by employee. To avoid delay, all questions must be answered)

Name of Employee			Employee's Social Security number
Employee's street address	City	State	Zip
Telephone number	Date of Birth / /	Gender ☐ Male ☐ Female	
☐ Right-Handed ☐ Left-Handed	Marital Status ☐ Married ☐ Divorced ☐ Single ☐ Widowed	Is Spouse Employed? ☐ Yes ☐ No	Number of Dependent Children

List Names and Dates of Birth of Spouse and Dependent Children

_____

_____

How many hours were you regularly working per week with your present employer?	Gross Annual Salary: *(During the 12 months just prior to your disability - for this employer only)*	Please indicate how you are paid *(check all that apply)*:
_____hrs.	$ _____	☐ Hourly ☐ Hourly Rate:_____ ☐ Salaried ☐ Other_____ ☐ Includes Commissions or Bonuses ☐ Includes Overtime Pay

Employer's Name and Policy Number			Employer's Telephone Number
Employer's street address	City	State	Zip
Your Occupation & Title	List essential duties of your job at the time of disability		

Date of Injury or Date First Noticed Symptoms of Sickness	Date you last worked because of Disability	Date you returned or expect to return to work on a Part-Time Basis	Date you returned or expect to return to work on a Full-Time Basis
/ /	/ /	/ /	/ /

Please describe all work activity, including Self-Employment, since the start of your disability.

_____ If none, initial here. _____

Is your injury or sickness related to your occupation? ☐ Yes ☐ No	If "Yes", explain: _____ _____	Did you file for Workers' Compensation? ☐ Yes ☐ No

Describe how and where injury occurred or describe the onset and nature of your medical condition including symptoms.

If more space is needed, please attach sheet of paper._____

_____

_____

Date First Treated / /	If "Hospital confined", give Name and Address of Hospital Hospital Name Street Address City State Zip

Confined From _____ Through _____

Have you ever had the same or similar condition in the past? ☐ Yes ☐ No If "Yes", when? _____	Treated By: Hospital Name	Street Address	City	State	Zip
	Doctor Name	Street Address	City	State	Zip

Information about your training, education, and experience
Please attach a copy of your resume, if applicable.

What is your level of education?
☐ Grade School ☐ High School ☐ Trade School ☐ College

☐ Other course *(please specify)* _____

List all previous occupations and the dates worked for each employer.

Employer's name	**Dates of employment**	**Occupation/type of work**

As a result of this disability, are you, your spouse or any of your dependent children receiving income from any of the following?

Yes	**No**	**Type**	**Amount**	**Date Began**	**Date Term.**	**Paid Weekly**	**Paid Monthly**
☐	☐	Sick Pay	$ _____	_____	_____	☐	☐
☐	☐	Salary Continuance	$ _____	_____	_____	☐	☐
☐	☐	Workers' Compensation	$ _____	_____	_____	☐	☐
☐	☐	Local, State or National Association or Society Disability Income Plan	$ _____	_____	_____	☐	☐
☐	☐	No Fault	$ _____	_____	_____	☐	☐
☐	☐	Unemployment Compensation disability	$ _____	_____	_____	☐	☐
☐	☐	Social Security Benefits *(disability or retirement)*	$ _____	_____	_____	☐	☐
☐	☐	Retirement income *(normal, early, or disability)*	$ _____	_____	_____	☐	☐
☐	☐	Other STD/LTD Benefits	$ _____	_____	_____	☐	☐
☐	☐	Other *(describe)*_____	$ _____	_____	_____	☐	☐

Have you applied, or do you plan to apply for benefits described above? ☐ Yes ☐ No

Type _____ Date Application filed _____

Type _____ Date Application filed _____

I CERTIFY THAT THE ANSWERS I HAVE MADE TO THE ABOVE QUESTIONS ARE COMPLETE AND TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF. I ACKNOWLEDGE THAT I HAVE READ THE FRAUD NOTICE ON PAGE 3 OF THIS FORM.

New York Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and stated value of the claim for each such violation.

_____ _____
Signature of Employee Date

Employee Name: _____
Employer Name: _____
Group Number: _____

FRAUD NOTICE

Unless specific state language is provided below, the following general fraud notice applies: 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.

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, Louisiana, New Mexico, West Virginia – 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."

Delaware, Florida, Idaho, Indiana, Oklahoma – 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, Colorado – 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.

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, Virginia and Washington – It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland, Alabama, Rhode Island and Texas – 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.

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.

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.

New York – Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and stated value of the claim for each such violation.

Employee Name: _____
Employer Name: _____
Group Number: _____

AUTHORIZATION FOR RELEASE OF INFORMATION
(excluding psychotherapy notes) (HIPAA Compliant) (to be signed and dated by the insured/claimant)

I authorize any licensed physician, any other medical practitioner or provider, pharmacist, pharmacy benefits manager, hospital, clinic, other medical or medically related facility, federal, state or local government agency, insurance or reinsuring company, the Social Security Administration, a Family Medical Leave Act (FMLA) vendor, consumer reporting agency or employer having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me, and any non-medical information about me (including any information, data or records regarding my Social Security FICA earnings history, Worker's Compensation, State Disability, pension, credit, earnings and employment history) to give any and all such information to authorized representatives of Aflac *excluding psychotherapy notes*, and including, but not limited to, any other mental or psychiatric records, medical, dental, hospital and pharmacy records (including psychiatric, alcohol, and drug abuse, and ***HIV/AIDS**** information) which may have been acquired in the course of examination or treatment. I understand the information obtained by use of this authorization will be used by Aflac and the above-described representatives to evaluate and adjudicate my current disability claim, and may be re-disclosed to (a) any medical, investigative, financial or vocational specialist or entity,(b) a Social Security vendor that may assist me in filing a claim with the Social Security Administration, (c) an FMLA vendor that may assist me in filing an FMLA claim, and (d) other insurance companies or their representatives to help investigate and adjudicate other insurance claims related to me. I understand Aflac may release information to my treating physicians and current or prospective employers relating to restrictions, accommodations and possible return to work. I understand the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA's Privacy rules.

This authorization is valid for two (2) years following the date of my signature. A photocopy of this authorization is as valid as the original. I understand my authorized representative or I have the right to request and receive a copy of this authorization and the information to which it pertains.

I understand I have the right to revoke this authorization by notifying Aflac in writing, of my revocation. However, such revocation is not effective to the extent Aflac has relied previously upon this authorization for the use or disclosure of my protected health information. I understand Aflac cannot condition the payment of a claim on my signing this authorization. However, I understand my revocation of, or my failure to sign this authorization may impair Aflac's ability to evaluate my current disability claim and as a result lack of required information may be a basis for denying that current disability claim for benefits.

* If you reside in ***California*****:** this authorization excludes the release of Human Immunodeficiency Virus (HIV) and Autoimmune Deficiency Disorder (AIDS) information and test results. Separate authorizations signed by the insured claimant, or employee-claimant (for self-insured business) are required each time results are released.

* If you reside in ***Connecticut, Maine, or Massachusetts:*** this authorization excludes the release of information about Human Immunodeficiency Virus (HIV) and Autoimmune Deficiency Disorder (AIDS). A separate authorization signed by the insured claimant, or employee-claimant (for self-insured business) are required each time results are released.

* If you reside in ***Vermont***: This authorization EXCLUDES the release of any information about previously administered HIV-related tests, including but not limited to tests for HIV antibodies, T-Cell counts, AIDS or ARC. The proposed insured is NOT AUTHORIZING Aflac to forward the results from any new test, requested by us, to any outside, non-affiliated company or entity not under specific contract with us to perform underwriting services, and Aflac shall comply, as applicable with the provisions of Title 8, Section 4724 (20) of the Vermont Statutes.

_____ _____
Claimant Name Date of Birth

_____ _____
Claimant Signature (or Authorized Representative) Date

Description of Personal Representative's Authority (If applicable):
(If signed by authorized representative, attach verification of identity)

Aflac

Employee Name: _____
Employer Name: _____
Group Number: _____

Fax 1 (866) 376-9480
Toll Free Phone 1 (888) 862-5732

NOTICE OF CLAIM FOR LIFE WAIVER OF PREMIUM BENEFITS

EMPLOYER'S OR ADMINISTRATOR'S STATEMENT **(All questions must be answered to avoid delay)**

Name of Employee			Occupation	Is Disability due to employment? ☐ Yes ☐ No
Date employed / /	Date insured / /	Date last worked / /	Reason for stopping work ☐ Disability ☐ Dismissed ☐ Resigned ☐ Layoff ☐ Retired ☐ FMLA ☐ Other LOA ☐ Other _____	

Date returned to work / / ☐ Full-Time ☐ Part-Time	If Part-Time, number of hours worked per week	If employee has not returned to work, estimated return to work date / /	Date employment terminated / /	Date disability insurance terminated / /

Required number of hrs. per week _____hrs.	Gross Annual Salary: *(During the 12 months just prior to your employee's disability)* $ _____	Please indicate how the employee is paid *(check all that apply)*: ☐ Hourly ☐ Hourly Rate:_____ ☐ Salaried ☐ Other_____ ☐ Includes Commissions or Bonuses ☐ Includes Overtime Pay

Employee eligible for:

Yes	No	Type	Amount	Date Began	Date Term.	Paid Weekly	Paid Monthly
☐	☐	Sick Pay	$ _____	_____	_____	☐	☐
☐	☐	Salary Continuance Benefits	$ _____	_____	_____	☐	☐
☐	☐	Workers' Compensation	$ _____	_____	_____	☐	☐
☐	☐	Local, State or National Association or Society Disability Income Plan	$ _____	_____	_____	☐	☐
☐	☐	No Fault	$ _____	_____	_____	☐	☐
☐	☐	Unemployment Compensation disability	$ _____	_____	_____	☐	☐
☐	☐	Social Security Benefits *(disability or retirement)*	$ _____	_____	_____	☐	☐
☐	☐	Retirement income *(normal, early, or disability)*	$ _____	_____	_____	☐	☐
☐	☐	Other STD/LTD Benefits	$ _____	_____	_____	☐	☐
☐	☐	Other *(describe)*_____	$ _____	_____	_____	☐	☐

Please attach a copy of the following documents to this form:
- The employee's Workers' Compensation claim(s) and Approval/Denial Notification if applicable
- The employee's current job description

I CERTIFY THAT THE ANSWERS I HAVE MADE TO THE ABOVE QUESTIONS ARE COMPLETE AND TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF. I ACKNOWLEDGE THAT I HAVE READ THE FRAUD NOTICE ON PAGE 3 OF THIS FORM.

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_____ _____
SIGNATURE DATE

NAME OF POLICYHOLDER *(COMPANY) AND POLICY NUMBER*	PRINT NAME & TITLE OF OFFICIAL REPRESENTATIVE
MAILING ADDRESS OF POLICYHOLDER *(COMPANY)* CITY STATE ZIP	
TELEPHONE NUMBER / EXT	FAX NUMBER / EMAIL ADDRESS

PLEASE RETURN THIS COMPLETED FORM TO THE EMPLOYEE

Aflac

Employee Name: _____
Employer Name: _____
Group Number: _____

Fax 1 (866) 376-9480
Toll Free Phone 1 (888) 862-5732

NOTICE OF CLAIM FOR LIFE WAIVER OF PREMIUM BENEFITS

ATTENDING PHYSICIAN'S STATEMENT

This statement must be filled-in completely by a physician without expense to insurance company.

(Please Print or Type)

Name of Patient (first, middle, last)			Gender ☐ M ☐ F	Date of Birth / /
Height	Weight	Blood Pressure (last visit) Systolic _____/ Diastolic _____		☐ Left-handed ☐ Right-handed

1. HISTORY

a. Is condition due to ☐ Accident? ☐ Sickness?
b. When did symptoms first appear or injury occur? Mo._____ Day _____ Year _____
c. Date patient was unable to work because of impairment Mo._____ Day _____ Year _____
d. Has patient ever had same or similar condition? ☐ Yes ☐ No If "Yes", state when and describe: _____
_____
_____
e. Is condition due to injury or sickness arising out of patient's employment? ☐ Yes ☐ No Please explain: _____
_____
f. Was this patient referred to you? ☐ Yes ☐ No If "Yes", by whom and what is their specialty? _____
_____
g. Have you referred this patient to another treating provider? ☐ Yes ☐ No If "Yes", to whom and what is their specialty?
_____

2. DIAGNOSIS

a. Diagnosis impacting function: _____ Diagnosis Code(s)_____
_____
Nature of treatment (including surgery with procedure code(s) and medications prescribed, if any, including dosage and frequency)
_____
_____
b. Secondary diagnosis impacting function:_____ Diagnosis Code(s)_____
_____
Nature of treatment (including surgery with procedure code(s) and medications prescribed, if any, including dosage and frequency).
_____
_____
c. Subjective symptoms: _____
_____
d. Objective findings (including current X-rays, EKGs, Laboratory Data and any clinical findings):_____
_____
_____

3. DATES OF TREATMENT FOR THIS CONDITION

a. Date of first visit Mo._____ Day _____ Year _____
b. Date of last visit Mo._____ Day _____ Year _____
c. Next office visit Mo._____ Day _____ Year _____
d. Frequency ☐ Weekly ☐ Monthly ☐ Other (specify) _____
_____

4. PROGRESS

a. Has patient ☐ Recovered? ☐ Improved? ☐ Unchanged? ☐ Retrogressed?
b. Is patient ☐ Ambulatory? ☐ House confined? ☐ Bed confined? ☐ Hospital confined?
If "Hospital Confined", give Name and Address of Hospital _____
Confined from _____ through _____

5. CARDIAC (if applicable)

Functional Capacity (American Heart Assoc. standards) ☐ Class 1 (No limitation) ☐ Class 2 (Slight limitation) ☐ Class 3 (Marked limitation) ☐ Class 4 (Complete limitation)

PLEASE COMPLETE BOTH SIDES OF THIS FORM

6. CURRENT FUNCTIONAL ABILITY

a. In an 8 hour day, what is the maximum number of hours your patient could perform each of these levels of activity? (please indicate appropriate number of hours):

____ Hrs. Sedentary Activity	10 lbs. maximum lifting or carrying articles. Walking/standing on occasion. Sitting 6 to 8 hours.
____ Hrs. Light Activity	20 lbs. maximum lifting, carrying 10 lbs. articles frequently, most jobs involving standing with a degree of pushing and pulling. Standing 6 to 8 hours.
____ Hrs. Medium Activity	50 lbs. maximum lifting with frequent lifting/carrying of up to 25 lbs. Frequent walking and standing.
____ Hrs. Heavy Activity	100 lbs. maximum lifting, frequent lifting/carrying of up to 50 lbs. Frequent walking and standing.

b. Please check appropriate box:

	Occasionally (0% to 33%)	Frequently (33% to 66%)	Continuously (66% to 100%)
Bending	☐	☐	☐
Climbing	☐	☐	☐
Reaching	☐	☐	☐
Kneeling	☐	☐	☐
Squatting	☐	☐	☐
Crawling	☐	☐	☐
Push/pull	☐ No. of lbs._____	☐ No. of lbs._____	☐ No. of lbs._____
Lifting (lbs.)	☐ No. of lbs._____	☐ No. of lbs._____	☐ No. of lbs._____

What is this assessment based on? ☐ observed activity ☐ measured capacity ☐ physical therapy report

c. Please list current restrictions (activities which should not be performed) and limitations (activities which cannot be performed) from activities not addressed above (i.e. driving, working at heights, etc.) Please be specific._____

_____

d. Upper Extremity Function - Please indicate upper extremity functional capabilities:

Simple grasp	☐ Left	☐ Right	Comments _____
Pinch	☐ Left	☐ Right	Comments _____
Fine manipulation	☐ Left	☐ Right	Comments _____
Power grip	☐ Left	☐ Right	Comments _____
Repetitive motion	☐ Left	☐ Right	Comments _____

7. MENTAL HEALTH ABILITY (if applicable)

☐ Patient is able to function under stress and engage in interpersonal relations (no limitation)
☐ Patient is able to function in most stress situations and engage in most interpersonal relations (slight limitation)
☐ Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations (moderate limitation)
☐ Patient is unable to engage in stress situations or engage in interpersonal relations (marked limitation)
☐ Patient has significant loss of psychological, physiological, personal, and social adjustments (severe limitation)

What behavior, attitudes or functional impairments are contributing to any restrictions and/or limitations related to a mental health condition?

_____

_____

8. RETURN TO WORK PLAN

a. Have you discussed a return to work plan with your patient? ☐ Yes ☐ No

b. Is this Patient motivated to return to his/her usual work or any work for which they are suited? ☐ Yes ☐ No
If "No", please explain_____

c. The date you released patient to return to work: _____/_____/_____ ☐ Full-time ☐ Reduced hours Number of hours: _____
Mo Day Year

d. Please identify your recommendations for any job modifications that would enable the patient to work. _____

_____

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_____ _____
ATTENDING PHYSICIAN'S SIGNATURE DATE

PHYSICIAN'S NAME (PLEASE PRINT)	DEGREE/SPECIALTY	
TELEPHONE NUMBER	FAX NUMBER	TAX ID #
OFFICE ADDRESS	CITY	STATE ZIP

PLEASE RETURN COMPLETED FORM TO YOUR PATIENT/THE EMPLOYEE