GROUP LIFE - Waiver of Premium / Permanent Total Disability (PTD) / Disability Extension Claim Form

INSTRUCTION PAGE

Claim form for Group Life Insurance Waiver of Premium for covered employees who have become disabled and unable to work.

Why apply for Group Life Waiver of Premium?

If a covered employee becomes disabled as defined by their Group Life plan, the Waiver of Premium benefit, featured on many of The Hartford's Group Life Insurance policies, offers a safeguard against losing valuable Group Life coverage. For employees who apply and are approved, no Group Life premiums are due after the Waiver of Premium waiting period has been satisfied, and coverage continues in accordance with the policy provisions.

**** Note: Group Life premiums are due and payable during the Waiver of Premium waiting period unless the employee has already converted coverage to an individual policy.**

EMPLOYER'S RESPONSIBILITY - SECTION 1

1. Detach and complete the Employer Section, sign and date. Without this information, the claim cannot continue.
2. If any portion of the Group Life coverage was elected, please attach a copy of the enrollment history for all benefit elections.
3. Attach a copy of the most recent Beneficiary Designation Form.
4. Give the remaining sections of the form, including the instruction sheet, to your employee. Ask him/her to complete the Employee Sections and return the claim form to The Hartford. (Your employee should detach the ***Attending Physician's Statement - Initial Report*** [Attending Physician Statement], pages 1 and 2, and forward to his/her physician for completion).
5. SUBMIT THE EMPLOYER'S STATEMENT AND ATTACHMENTS DIRECTLY TO THE HARTFORD BEFORE THE CLAIM SUBMISSION PERIOD* SPECIFIED UNDER THE POLICY.

**** Please verify if the employee qualifies for any other group benefits through The Hartford and submit a claim accordingly.**

EMPLOYEE'S RESPONSIBILITY - SECTION 2

1. Fully complete Employee Section - pages 1 and 2.
2. Read, sign and date Important Notice and Claim Certification, Employee Section - page 3.
3. Read, complete, sign and date the Authorization at the bottom, Employee Section 2 - pages 4-5.
4. Remove the Attending Physician's Statement - Initial Report - pages 1 and 2; and:
   a) Complete the Employee information at the top of the Attending Physician's Statement - Initial Report.
   b) Provide the Attending Physician's Statement - Initial Report, to the physician certifying your disability. Ask your physician to complete the form and return it within 10 days to The Hartford. Be advised that you are responsible for any fees charged by your physician for completion of this form.
5. TO QUALIFY FOR BENEFITS SUBMIT THE FOLLOWING BEFORE THE SUBMISSION PERIOD* SPECIFIED UNDER YOUR GROUP PLAN:
   a) Completed Employee Sections and all attachments. Make a copy to keep with your records;
   b) The Attending Physician's Statement - Initial Report, which should be sent separately by your physician;
   c) The Employer section, which should be sent separately.
6. Please follow up to make sure that this claim form, all attachments, and the ***Attending Physician's Statement - Initial Report***, are received by The Hartford within the submission period* specified under your Group Life plan.

SEND THE CLAIM FORM TO:
THE HARTFORD
P.O. BOX 14296
Lexington, KY 40512-4296

FAX TO:
(877) 467-3037
E-MAIL TO:
gbclaimcspw@thehartford.com

For questions about how to complete this form call The Hartford Toll-free at:
1-800-445-9057

**** Please review your plan booklet to verify the submission period applicable to you.**

Clear Form

GROUP LIFE - Waiver of Premium / Permanent Total Disability (PTD) / Disability Extension Claim Form

THE HARTFORD

EMPLOYER SECTION 1

This is a time-sensitive document, please review the plan booklet to verify the submission period applicable.

***Please verify if the employee qualifies for any other group benefits through The Hartford and submit the claim accordingly.**

A. INFORMATION ABOUT YOUR COMPANY

Company Name

Address (Street, City, State, Zip Code)

Name and address of division where employee works, if different from above:

Group Policy Number	Telephone Number ( )	Fax Number ( )	E-Mail address

B. INFORMATION ABOUT YOUR EMPLOYEE

Employee's Name	Social Security Number	Date of Birth

Address (Street, City, State, Zip Code)	Telephone Number ( )

Date hired: ☐ Full time ☐ Part time	Date Group Life Insurance became effective: _____	Last day worked: _____	Premiums paid to date? ☐ Yes ☐ No

Employee Division ☐ Exempt ☐ Non-exempt ☐ Salaried ☐ Hourly

Group Life: Insurance coverage amount: **Basic Life $** _____ **Supplemental Life $** _____
(Attach enrollment forms & beneficiary form.)

Permanent Total Disability Benefits:

Amount of **Basic Life** Insurance $_____ Amount of **Supplemental Life** Insurance $ _____

Amount of Permanent Total Disability requested $ _____ Number of hours scheduled to work weekly _____

Rate of Annual Basic Earnings on date last worked: $ _____ per ☐ Hour ☐ Week ☐ Month ☐ Year
(Attach W-2, if applicable)

Do earnings include commissions, bonuses or overtime? ☐ Yes ☐ No If "Yes," please specify:

Are employee's eligible dependents covered by Waiver of Premium or Disability Extension benefits? ☐ Yes ☐ No
If "Yes", please provide amounts of Group Life coverage and enrollment history:

Spouse's Name:_____ Date of Birth: _____ Coverage Amount: _____
Child's Name: _____ Date of Birth: _____ Coverage Amount: _____
Child's Name: _____ Date of Birth: _____ Coverage Amount: _____

Has employment been terminated/retired? ☐ Yes ☐ No If "Yes," date:_____

Was an application for conversion offered? ☐ Yes ☐ No

C. INFORMATION ABOUT THE DISABILITY

Before the employee became totally disabled, were any changes made to the employee's job responsibilities because of the disabling condition? ☐ Yes ☐ No. If "Yes," what were the changes and when were they made?_____

What was the employee's permanent job or occupation title on his or her last day at work?_____

How long had the employee been in this job? _____ Full time? ☐ Yes ☐ No

Date employee is expected to, or did return to work: _____ Why did employee stop working?_____

Is the cause of employee's condition work related? ☐ Yes ☐ No

Is your employee receiving income from other sources? e.g.: ☐ Short Term Disability ☐ Long Term Disability
☐ Workers' Compensation ☐ Social Security **(If applicable, provide name and address of insurance carrier:)**

D. REQUIRED ATTACHMENTS AND SIGNATURE

For Voluntary Group Life Insurance coverage, attach a copy of the enrollment form history, and/or copies of the Electronic Benefits (screen prints). I hereby certify that the information provided in the Employer's Section is true and complete to the records of the Employer, I agree that this information is subject to audit by Hartford Life Insurance Company or Hartford Life and Accident Insurance Company or Hartford Life Group Insurance Company and/or its representatives.

Name *(Please print or type)* Title

Signature of Employer Representative Date ( ) Telephone Number

GROUP LIFE - Waiver of Premium / Permanent Total Disability (PTD) / Disability Extension Claim Form

EMPLOYEE SECTION 2
This is a time-sensitive document

***Please review your plan booklet to verify the submission period applicable to you.**

Group Policy Number: _____

Employer Name: _____

Be sure to answer all questions - missing information may delay your claim.

A. INFORMATION ABOUT YOU

Name: ☐ Male ☐ Female

Address:

Personal Cell Phone Number: ( ) _____ Alternate Telephone Number: ( ) _____ E-Mail address: _____

May we have your authorization to leave confidential medical and benefit information on your personal cell phone? ☐ Yes ☐ No

Signature: _____ Date: _____

If your Policy contains a Permanent and Total Disability provision and you are eligible and would like to apply, please complete below:
Amount of Permanent Total Disability (PTD) requested*: $ _____

*__Note__: The amount requested may not exceed the percentage of the Employee/Insured's Life Insurance Amount set forth in the policy and is subject to the minimum and maximum amounts contained in the Policy. **As a result of electing the Permanent Total Disability benefit, the total face amount of your group life insurance coverage will be reduced by the amount of the Permanent Total Disability benefit.**

At the time of your TOTAL disability began, were you working more than one job (including self-employment)? ☐ Yes ☐ No
If "Yes". provide the name, address and phone number of other employers and indicate when you worked (or were self-employed).

Please indicate your educational history: (Check or Circle last year completed.)

Education through High School
1 2 3 4

College
1 2 3 4

☐ Masters ☐ Ph.D.

Are you now attending school? ☐ Yes ☐ No

Trade or technical school: (Describe course of study.)

_____

_____

_____

Describe your last four jobs. (Begin with your most recent job.)

	Company	Job Title	Duties	Years
(a)				
(b)				
(c)				
(d)				

Are you receiving any income from other sources?

	Amount	Name	Address	Phone
Short Term / Long Term Disability	$			( )
Workers' Compensation	$			( )
Individual Disability	$			( )
Self-employment or Part-time work	$			( )

B. INFORMATION ABOUT THE CONDITION CAUSING YOUR DISABILITY

Describe your medical condition: _____

Why did you stop working? _____

If caused by an illness, have you had this illness before? ☐ Yes ☐ No If "Yes," when? _____

If caused by an injury, when, where and how did the injury occur? _____

Date you were first treated by a Medical Provider for the disabling illness or injury: _____

Name of Medical Provider:

Before you stopped working, did your condition require you to change your job or the way you did your job? ☐ Yes ☐ No
If "Yes," explain:

What aspect of your condition made you unable to work?

Is the cause of your condition related to your job? ☐ Yes ☐ No If "Yes," explain: _____

What important duties of your job are you unable to perform? _____

Are you now engaged in the duties of any occupation or endeavor for wages, profit, compensation or volunteerism? ☐ Yes ☐ No

C. INFORMATION ABOUT YOUR DISABILITY

Last day you physically reported to work: _____ Since that date, have you done any work? ☐ Yes ☐ No
If "Yes," please indicate dates worked, name and address of employer and amount earned.

Have you returned to work in any capacity? ☐ Yes ☐ No If you have not returned to work, do you expect to? ☐ Yes ☐ No

If "Yes," part-time *(date)* _____ full-time *(date)* _____

D. INFORMATION ABOUT YOUR PHYSICIANS

List all physicians you have seen for this condition *(attach a separate sheet if needed)*

Doctor's Name | Specialty | Dates seen

Address

City/State/Zip Code | Telephone Number ( ) | FAX Number ( )

Doctor's Name | Specialty | Dates seen

Address

City, State, Zip Code | Telephone Number ( ) | FAX Number ( )

Doctor's Name | Specialty | Dates seen

Address

City, State, Zip Code | Telephone Number ( ) | FAX Number ( )

IMPORTANT NOTICE

E. EMPLOYEE'S SIGNATURE
Please read the statement that applies to your state of residence and sign the bottom of the page.

For residents of all states EXCEPT Arizona, California, Colorado, Florida, Kentucky, Maine, Maryland, New Jersey, New York, Oregon Pennsylvania, Puerto Rico, Tennessee and Washington: 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.

For Residents of Arizona: For your protection, Arizona law requires the following 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.

For Residents of California: For your protection, California law requires the following to appear on this form: Any person who knowingly presents 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.

For residents of 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 award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

For residents of 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.

For residents of Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim or an application for insurance 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.

For residents of Maine, Tennessee 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 and denial of insurance benefits.

For residents of Maryland: 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.

For residents of New Jersey: Any person who knowingly files a statement of claim containing any false or misleading nformation is subject to criminal and civil penalties. Any person who includes any false or misleading information on an application for insurance policy is subject to criminal and civil penalties.

For residents of 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.

For residents of Oregon: 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 is subject to a denial and/or reduction in insurance benefits and may be subject to any civil penalties available.

For residents of 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 hereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

For residents of 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 by 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 be 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.

For residents of Virginia: 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 may have violated the state law.

The statements contained in this application for Group Life Waiver of Premium / Permanent Total Disability/ Disability Extension Application are true and complete to the best of my knowledge and belief.

Signature _____ Date _____

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I allow all doctors, hospitals, other health care providers, pharmacy, pharmacy benefit managers, government agencies (including, but not limited to, Federal, State or Local , and the Social Security Administration and Veterans Administration), insurers, employers, financial institutions, educational institutions, health plans, health insurance carriers, policyholders, contract holders, vendors, health and benefit insurers and administrators or their successors ("Records Holders") to give to and discuss with The Hartford, the following personal, private, or privileged information, records, or documents:

Any and all medical information or records, including medical histories, physical, mental, or diagnostic examinations, pharmaceutical records, and treatment notes, and including information regarding HIV/AIDS, communicable diseases, alcohol or drug abuse, and mental health; work and performance information and history, including job duties and earnings; information on any insurance coverage and claims filed, including all records and information related to such coverage and claims; financial information, including pension benefits and bank records; business transaction billing and payment records; academic transcripts; and any and all information concerning Social Security or other government benefits, including monthly benefit amounts, monthly payment amounts, entitlement dates, and information from my Master Beneficiary Record. The information obtained by use of this Authorization will be used by The Hartford (including subsidiaries and affiliates) for the purpose of evaluating and administering my claim(s) for benefits and /or leave request(s) and/or request(s) for accommodation. Such information shall be referred to herein collectively as "My Information."

I understand that once My Information has been disclosed to The Hartford as permitted under this Authorization, it may be re-disclosed by The Hartford as permitted by law or my further authorization. I authorize The Hartford to use or disclose My Information (i) to my employer for: a) functions related to accommodating my restrictions/limitations, including in accordance with law; b) responding to claims related to accommodation, adverse or discriminatory treatment related to my claim or condition; c) responding to complaints by me or my representative relating to benefits, leave or accommodation; d) responding to any litigation, agency or regulatory proceeding, or lawful subpoena (including regarding employment claims); e) federal, state, or other leave administration; f) fulfilling fiduciary obligations under my benefit plan; or (g) claim, other audits or benefit program reviews; (ii) to administrators or other service providers, including health and wellness vendors, of my employer's benefit plan(s) and/or programs, including leave management, for plan, benefit, or program related functions or data aggregation and analysis; (iii) to any electronic claim systems or programs or third party vendors used for claims administration or processing or to any insurance broker to carry out functions related to my benefit plan/program or claim; (iv) to any health care professional who has treated or evaluated me or who may do so; (v) to other persons or entities performing business, medical, or legal services related to my claim; (vi) for other insurance or reinsurance purposes, including workers' compensation insurance, Social Security Disability insurance, or subrogation or reimbursement purposes; (vii) as may be lawfully required; (viii) as may be reasonably necessary to protect the personal safety of others or myself; (ix) as may be reasonably necessary to respond to regulatory or similar complaints; and (x) as may be reasonably necessary to prevent or detect perpetration of a fraud (all entities and individuals listed herein including The Hartford defined as "Benefits Manager(s)")

I understand that My Information disclosed to Benefits Managers pertaining to certain alcohol or drug abuse treatment or HIV/AIDS or other communicable or sexually-transmitted disease is protected by federal (42 CFR Part 2) and state confidentiality rules and statutes, which prohibit any further disclosure of this information without my express written consent, or as otherwise permitted by such rules and statutes. I understand that a general authorization for the release of medical or other information is NOT sufficient for release of these types of records.

Therefore:

☐ **If any of my records contain information about alcohol or drug abuse, then, by checking this box, I hereby expressly allow my Benefits Managers to use or give out such information to evaluate, analyze, manage and/or administer the benefits program. I understand that the federal rules restrict any use of the Information to criminally investigate or prosecute any drug or alcohol abuse patient.**

☐ **If any of my records contain information about HIV/AIDS or other communicable or sexually transmitted disease, then, by checking this box, I hereby expressly allow my Benefits Managers to use or give out such information to evaluate, analyze, manage and/or administer the benefits program.**

(Continue to next page)

I understand that once my Information is given out as allowed in this form, federal privacy laws may not protect it and it may be re-disclosed by The Hartford. I also understand that information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient. The Authorizations set forth herein expire two years from the date listed below, or upon my revocation, if earlier, but will not exceed the term of my coverage under the policy(ies) or benefit plan or program, except as may be reasonably necessary to prevent or detect perpetration of a fraud, respond to regulatory or similar complaints, or protect the personal safety of others or myself.

If I change my mind about this Authorization before that time is up, I can tell my Records Holders and The Hartford in writing that I do not want them to share any more information with other parties. If I revoke my Authorization by telling them in writing to stop sharing information with other parties, it will not change any actions they took before I revoked my permission. If I do not sign this Authorization, it will not affect how my health care providers treat me. However, if I do not sign, The Hartford may not be able to review my claim and determine whether I am eligible for benefits. This may result in denial of my request for benefits.

The Information released under this Authorization can be submitted to The Hartford electronically, by phone or fax, or by mail. I know I can see or copy the records given to The Hartford based on this Authorization. I agree that a copy of this Authorization may be treated as a signed original. I understand that I am entitled to receive a copy of this Authorization upon request. If there is a conflict between a prior request for restriction on the disclosure of My Information and this Authorization, this Authorization will control.

NOTICE TO INFORMATION PROVIDERS:
The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family members genetic tests, the fact that an individual or an individuals' family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. *Please note that it is appropriate under GINA to provide family medical history when an employee is requesting leave to care for a family member.*

Claimant's Name	**Date of Birth**
Employer's Name	**Date**
Claimant's (or Legal Representative's) Signature	**Legal Representative's Name and Relationship**

Form must be signed in order to be considered valid.

Please fax the completed form to:
Fax Number: 877-467-3037
The Hartford
P.O. Box 14296
Lexington, KY 40512-4296

Clear Form

ATTENDING PHYSICIAN'S STATEMENT - INITIAL REPORT

THE HARTFORD

To be completed by the Employee

Patient Name:	Date of Birth:	Insured ID Number:

Patient Address: (Street, City, State & Zip Code)

To be completed by the Provider - Use current information from your patient's most recent office visit or examination to complete this form. (The patient is responsible for the completion of this form without expense to the Company.)

Patient's condition is the result of: ☐ Sickness ☐ Injury ☐ Pregnancy

If pregnancy, what is the expected date of delivery? _____ Month _____ Day _____ Year

Is condition due to illness or an injury that is related to: ☐ Work Activity ☐ Motor Vehicle Accident

Medical Conditions Impacting Activity

Primary condition: _____ ICD-9 Code: ☐ _____ ICD-10 Code: ☐ _____

Secondary condition(s): _____ ICD-9 Code: ☐ _____ ICD-10 Code(s): ☐ _____

Subjective symptoms: _____

Objective Physical Findings (Please include office notes for date(s): _____ to _____

Pertinent Test Results (list all results or attach test results):

Test: _____ Date: _____ Results: _____

Test: _____ Date: _____ Results: _____

Condition(s) Specific Medications, Dosage and Frequency:

Treatments

Date your patient reported stopping work: _____ Date of disability: _____ Expected Return to Work Date: _____

Date you first treated this patient: _____ Date you first treated this patient for this condition: _____

Date of reported onset of this condition: _____ Date of most recent treatment: _____

How often has patient been seen/treated for this condition? _____ Date of next office visit: _____

Current Treatment Plan: _____

Has surgery been performed? ☐ Yes ☐ No Is surgery planned? ☐ Yes ☐ No If "Yes," Date: _____

Procedure: _____ CPT Code: _____

Was patient hospitalized for this condition? ☐ Yes ☐ No If "Yes," Date(s) admitted: _____ Date(s) Discharged: _____

Name of Hospital: _____ Telephone Number of Hospital: (____) _____

Has patient been referred to any other physician? ☐ Yes ☐ No If "Yes," Date(s) of Referral: _____ _____

Other Physician Name: _____ Phone Number: (____) _____ Specialty: _____

Other Physician Name _____ Phone Number: (____) _____ Specialty: _____

Patient Name: Date of Birth: Insured ID Number:

Complete this section to the best of your ability. Generalized comments such as "unable to work" may delay your patient's disability benefits.

Based on your medical findings and opinion, address the full range of restrictions/limitations at the time patient stopped working, reduced their work schedule or initially visited your office for this condition, noting that we will conclude there are no restrictions on function unless specified below.

Restrictions/Limitations based on office visit dated: _____

In an 8 hour period the patient is able to: (select either continuous or intermittent)

	Continuously with standard breaks		Intermittently with standard breaks	If intermittent circle time for each section below	
				Hours at one time	Total hours/8 hours
Sit	☐	or	☐	1 2 3 4 5 6 7 8	1 2 3 4 5 6 7 8
Stand	☐	or	☐	1 2 3 4 5 6 7 8	1 2 3 4 5 6 7 8
Walk	☐	or	☐	1 2 3 4 5 6 7 8	1 2 3 4 5 6 7 8

Provide medical findings/rationale for your opinion if patient is unable to continuously sit, stand or walk:

_____

_____

Activity Ability (with normal breaks)	Never 0 hours	Occasionally up to 2.5 hours	Frequently 2.5 to 5.5 hours	Constantly 5.5 to 8 hours	Please indicate diagnosis, symptoms, exam findings, and/or imaging that supports the restrictions/limitations
Bend at waist	☐	☐	☐	☐	
Kneel/crouch	☐	☐	☐	☐	
Climb	☐	☐	☐	☐	
Balance	☐	☐	☐	☐	
Drive	☐	☐	☐	☐	
Lift - Indicate weight in pounds		_____ lbs.	_____ lbs.	_____ lbs.	.
Other Restrictions (if any)_____	☐	☐	☐	☐	
Hand Dominance: ☐ Right ☐ Left					
Upper Extremity Activity (not load bearing) Specify right (R) or left (L) if not bilateral					
Fine manipulation (fingering, keyboard)	☐	☐	☐	☐	
Gross manipulation (grip/grasp, handle)	☐	☐	☐	☐	
Reach (extend arms) above shoulder	☐	☐	☐	☐	
Reach (extend arms) below shoulder at desk or workbench level	☐	☐	☐	☐	

Please attach copies of imaging results/tests

Expected duration of any restriction(s) or limitation(s) listed above: _____

Current Status (Please check one): ☐ Recovered ☐ Improved ☐ Unchanged ☐ Retrogressed

Additional Comments (If Necessary): _____

Does the patient have a psychiatric / cognitive impairment? ☐ Yes ☐ No If "Yes", please describe the extent of the impairment and its etiology: _____

In your opinion is the patient competent to endorse checks and direct the use of the proceeds? ☐ Yes ☐ No

Provider's Name: (please print or type)	EIN Number:	License Number:

Telephone Number: ( )	Fax Number: ( )	Degree:	Specialty:

Street Address (Street, City, State & Zip Code):

Office Contact and Telephone Number:

Provider's Signature: Date signed: