HARTFORD LIFE INSURANCE COMPANY
HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

ATTENDING PHYSICIAN'S STATEMENT OF CONTINUED DISABILITY

To be completed by the Employee

Name of patient ______ Social Security Number ______ D.O.B ______

Address of patient ______
Street *City* *State or Province* *ZIp Code or Postal Code*

Employer's name *(and division, if applicable)* ______

I hereby authorize release of information on this form by the below named physician for the purpose of claim processing.

SIgned *(Patient)* ______ Date: ______

To be completed by the Attending Physician *(The patient is responsible for the completion of this form without expense to the Company)*

DIAGNOSIS

Primary diagnosis: ______ ICD-9 Code: ______

Secondary diagnosis(es): ______ ICD-9 Code(s): ______

Subjective symptoms: ______

Test Results (list all results, or enclose test):

Test: ______ Date: ______ Results: ______

Test: ______ Date: ______ Results: ______

Physical examination findings: ______

If pregnancy, indicate LMP date: Month ______ Day ______ Year ______

TREATMENTS

Date of most recent treatment: ______

How often has patient been seen/treated? ______ Date of next office visit: ______

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

Name and address: ______

______ Specialty: ______

Nature of treatment for this condition: ______

Has surgery been performed? ☐ 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 and address of hospital(s): ______

Progress *(Please check one.)*: ☐ Recovered ☐ Improved ☐ Unchanged ☐ Retrogressed

ATTENDING PHYSICIAN'S STATEMENT OF CONTINUED DISABILITY (Side two)

IMPAIRMENT

If the patient's ability to perform any of the following activities is limited by his/her disorder, please describe the extent of the limitation and its expected duration.

Standing: ______________________________

Walking: ______________________________

Sitting: ______________________________

Lifting/carrying: ______________________________

Reaching/working overhead: ______________________________

Pushing: ______________________________

Pulling: ______________________________

Driving: ______________________________

Keyboard use/repetitive hand motion: ______________________________

If any other activities are limited, please specify the activities and the limitations: ______________________________

If the patient's vision is impaired, please describe the extent of the impairment: ______________________________

Do you believe the patient is competent to endorse checks and direct the use of the proceeds thereof? ☐ Yes ☐ No

What is the psychiatric impairment (*if applicable)?*

- ☐ Inadequate information to make assessment.
- ☐ Essentially good functioning in all areas. Occupationally and socially effective.
- ☐ Slight difficulty in occupational functioning, but generally functioning well. Has some meaningful interpersonal relationships.
- ☐ Moderate impairment in occupational functioning. Limited in performing some occupational duties.
- ☐ Major impairment in several areas--work, family relations. Avoidant behavior, neglects family, is unable to work.
- ☐ Inability to function in almost all areas

If physical or psychiatric limitations exist, how long do you feel limitations will last? ______________________________

Attending Physician's Name: ______________________________ Telephone # ____________

(Please print or type.)

License No. ______________________________ FAX # ____________

SS# or E.I.N.#: ____________ Degree: ____________ Specialty: ____________

Street Address: ____________ City: ____________ State: ______ Zip Code: ____________

Signature: ______________________________ Date signed: ____________