Statement for Long Term Disability Income Benefits

This application package is divided into four sections, as follows:

Section I **Employer's Statement** - to be completed by the employer's authorized representative. Be sure to provide any necessary attachments (see Section K)

Section Ic. **Information for Group Life Premium Waiver Benefits –** to be completed by the employer's authorized representative if the employer also has a Group Life Insurance Policy with Kanawha Insurance Company that includes a Premium Waiver benefit. Be sure to provide any necessary attachments (see Section K)

Section II **Employee's Statement** - to be completed by the employee who is applying for Long Term Disability benefits. Please attach a copy of the employee's driver's license.

Section III **Authorization to Obtain Information** - to be signed by the employee.

Section IV **Attending Physician's Statement** - to be completed by the physician who is treating the employee.

Please see that all sections are fully completed and signed. Forward the completed application to:

Kanawha Insurance Company
P.O. Box 14294
Lexington KY 40512-4294

Questions call: (800) 957-7121

To Be Completed by the Employer — Section I – Employer's statement

This claim is for *(Employee's Name)*_____

Social Security Number _____ Date of Birth _____

Employee's Address _____

A. Information about the Employer

Company's Name _____ Group Policy Number _____

Address _____

Name and Address of Division Where Employee Works *(if different from above)*

_____

Telephone Number _____ Fax Number_____

B. Information about the Employee

Date employee was hired _____ Date employee became insured under this plan _____

What was the employee's regularly scheduled work week? Hours per Week _____

Was the employee's LTD insurance issued on the basis of an Evidence of Insurability? □ Yes □ No If "Yes," attach copy.

Was the employee insured under your prior LTD policy? □ Yes □ No

If "Yes," please provide the inclusive date of coverage. From _____Through _____

Has the employee been terminated? □ Yes □ No If "Yes," date _____

Reason _____

Statement for Long Term Disability Income Benefits

Was the employee on Qualified Family Leave when disability began? □ Yes □ No

Did LTD insurance continue while on Family Leave? □ Yes □ No

Date Leave of Absence started under Family Leave Act _____

C. Information for Group Life Premium Waiver Benefits

Does the employee also have Group Life Insurance coverage with Kanawha Insurance Company? ☐ Yes ☐ No If "Yes," provide the following information: Basic Amount $_____ Supplement Amount $_____

Effective Date of Group Life Insurance Coverage _____

D. Information about the Claim

What percentage of the LTD benefit is taxable? _____%

E. Information about the Claim

What was the employee's permanent job on his or her last date of work? _____

Were there any changes to the employee's job responsibilities due to the disabling condition before the employee became totally disabled*?*

□ Yes □ No If "Yes," what were the changes, and where were they made?

_____

_____

How long had the employee been in this job? _____

Last day employee actually worked? _____

On that day, did the employee work a full day? □ Yes □ No If "No," how many hours were worked? _____

Why did employee stop working? _____

Is the employee's condition work related? □ Yes □ No

Has a claim been filed with Workers' Compensation? □ Yes □ No If "Yes," send initial report of illness or injury or award notice.

Workers Compensation Carrier _____ Telephone Number _____

Address _____

Date employee is expected/did return to work? _____ Full time? □ Yes □ No

F. Information about Your Pension Plan (Do not complete for maternity claim.)

Do you have a pension plan? □ Yes □ No If "Yes," what type? (Check as many as applicable.)

□ Defined benefit □ Defined contribution □ 401 K □ Profit Sharing □ Other_____

Is the employee eligible for your pension plan? □ Yes □ No If "No," why? _____

If eligible does the employee participate? □ Yes □ No If "No," why? _____

If the employee is participating, when is he or she eligible for benefits under the plan?_____

At what point does the employee qualify for a full pension?_____

Is there a Disability Retirement Option available to this employee? □ Yes □ No

Statement for Long Term Disability Income Benefits

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G. Information about Your Rehire or Return-to-Work Policies

Does your company have a rehire or return-to-work policy for disabled employees? ☐ Yes ☐ No

What is the name, title and telephone number of the manager we should contact if we identify a rehabilitation or return-to-work option?

_____

H. Information about Employee's Salary

Basic Salary or wage immediately prior to cessation of work because of disability (exclude bonuses, overtime, pay, etc.)$ _____

☐ Monthly ☐ Weekly ☐ Annually ☐ Hourly Number of hours/week _____

Is this employee eligible for salary continuation? ☐ Yes ☐ No If "Yes," what is the weekly amount?_____

When do benefits begin? _____ End? _____

Will the employee file for Short Term or State Disability benefits? ☐ Yes ☐ No If "Yes," what is the weekly amount?_____

When do benefits begin? _____ End? _____

List any other sources of income to which the employee is entitled as a result of this disability:

_____

I. Information about the Physical Aspects of the Employee's Job

Check the items below that relate to the employee's job using the definitions below for the frequency: Indicate the average weight when applicable.

Not Applicable means the person does not perform this activity.
Occasionally means the person does the activity up to 33% of the time.
Frequently means the person does the activity 34% to 66% of the time.
Continuously means the person does the activity 67% to 100% of the time.

	Frequency of Occurrence			
Activity	**N/A**	**Occasionally**	**Frequently**	**Continuously**
☐ Standing	☐	☐	☐	☐
☐ Walking	☐	☐	☐	☐
☐ Sitting	☐	☐	☐	☐
☐ Balancing	☐	☐	☐	☐
☐ Stooping	☐	☐	☐	☐
☐ Kneeling	☐	☐	☐	☐
☐ Crouching	☐	☐	☐	☐
☐ Crawling	☐	☐	☐	☐
☐ Reaching/working overhead	☐	☐	☐	☐
☐ Keyboard Use/Repetitive Hand Motion	☐	☐	☐	☐

Activity	**Description**	**Frequency**	**Weight**
☐ Pushing	_____	_____	_____lbs.
☐ Pulling	_____	_____	_____lbs.
☐ Lifting	_____	_____	_____lbs.
☐ Carrying	_____	_____	_____lbs.

Can the job be performed by alternating sitting and standing? ☐ Yes ☐ No

Statement for Long Term Disability Income Benefits

What are the major tasks of the employee's occupation? Indicate the percentage of the employee's workday that is spent on each of these tasks?

_____ _____%

_____ _____%

_____ _____%

J. Information about the Job as it Relates to the Disability

Can the job be modified to accommodate the disability either temporarily or permanently? □ Yes □ No If "Yes," explain:

_____

Is it possible to offer the employee assistance in doing the job *(e.g., through the use of technology or personal assistance)*? □ Yes □ No

If "Yes," explain: _____

K. Required Attachments and Signature

- Please attach a copy of the employee's job description.
- If the employee contributes to the premiums for LTD or Group Life Insurance Coverage, attach a copy of the enrollment form and/or copies of the last two Flexible Benefits Election forms.
- If salary is based on aW-2, K-1, 1099, or a similar document, attach a copy of the document.
- If you have medical information from the employee's file relating to this disability, please attach copies.
- If a Workers' Compensation claim is filed, send initial report of injury or illness and award notice.

Name of person completing this form (*if this claim is approved for disability benefits, the benefit check will be sent to the employee with a copy to you).*

Name *(Please print or type)*_____ Title _____

Signature _____ Date_____

Statement for Long Term Disability Income Benefits

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To Be Completed by the Employee **Section II – Employee's statement**

(Be sure to answer all questions — Failure to do so may delay your claim)

A. Information about You

Last name _____ First _____ Middle Initial _____

Social Security Number _____

Address _____

Telephone Number _____ Date of Birth _____

Height _____ Weight _____

☐ Male ☐ Female ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Your Employer *(include division, if applicable)* _____

Occupation _____

When your disability began, did you have more than one employer *(includes self-employment)*? ☐ Yes ☐ No If "Yes," please provide the name, address and phone number of that employer. Indicate the dates when you worked *(or were self-employed)*.

_____

Please indicate the extent of your formal education *(Circle one)*

High School 9 10 11 12 College 1 2 3 4

Masters_____ Ph.D. _____

Trade School _____ Current Occupational Licenses _____

Briefly describe your past work experience for the last 20 years *(Begin with your most recent job)*

Job Title	Duties	Years Worked
A)		
B)		
C)		
D)		

Now, or at some time in the future, would you be interested in seeking rehabilitation to some other kind of work)? ☐ Yes ☐ No

Have you contacted your State Department of Vocational Rehabilitation)? ☐ Yes ☐ No If "Yes," please include the name, address and telephone number of your counselor.

_____

_____

B. Information About your Family (required to determine your eligibility for Social Security Benefits)

Spouse's Name _____ Spouse's Social Security Number _____

Date of Birth _____ If your spouse employed? ☐ Yes ☐ No Retired? ☐ Yes ☐ No

Do you have any children under Age 19? ☐ Yes ☐ No If "Yes," name, date of birth and social security number of each child.

_____

Do you have any children with disabilities (regardless of age)? ☐ Yes ☐ No If "Yes," name, date of birth and social security number of each child. _____

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C. Information about the Condition Causing your Disability

1a. For Illness, Injury or Pregnancy, answer the following questions

What were your first symptoms? _____

When did you first notice them? _____

Have you had this illness before? □ Yes □ No If "Yes," When?_____

1b. Next to any Activity of Daily Living (ADL), please place the number shown next to the statement that most accurately reflects your ability/ inability to perform each: 1 = I can perform this activity independently; 2 = I can perform this activity with the use of equipment or adaptive devices; 3 = I cannot perform this activity.

Bathe (tub, shower, or sponge) _____Transfer from Bed to Chair_____

Dress _____Voluntary bladder and bowel control or ability to maintain a reasonable level of personal hygiene. _____

Toilet_____ Feed yourself with food that has been prepared and made available to you. _____

If you indicated **(3)** for any of the above activities, please describe the impairment and restrictions to your functionality that preclude you from performing the activity. _____

_____

Have you suffered a severe Cognitive Impairment that renders you unable to perform common tasks, such as using the phone, money management, or medication management? □ Yes □ No If "Yes," describe: _____

2. For an injury, answer the following questions:

When, where and how did the injury occur? _____

3. For Illness, Injury or Pregnancy, answer the following questions:

Date you were first treated by a physician? _____ Name of Physician_____

Address of Physician _____

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 your condition related to your occupation? □ Yes □ No If "Yes," explain:

_____

Have you filed, or do you intend to file a Workers' Compensation claim? □ Yes □ No No If "No," explain:

_____

D. Information about the Disability

Last day you worked before the disability _____

Did you work a full day? □ Yes □ No If "No," explain: _____

Date you were first unable to work _____

Since that date, have you done any work? □ Yes □ No If "Yes," please indicate dates worked, name of employer, and amount earned.

_____

If you have not returned to work, do you expect to? □ Yes Part time *(date)* _____ Full time *(date)* _____ □ No

Statement for Long Term Disability Income Benefits

E. Information about Physicians and Hospitals

First medical attention for the current disability was given by (complete below)

Doctor's Name _____Telephone _____

Specialty _____ Fax _____

Address _____

Dates seen_____

List all Physicians and Hospitals you have seen for this condition (attach separate sheet, if needed)

Doctor's Name _____Telephone _____

Specialty _____ Fax _____

Address _____

Dates seen_____

Hospital _____

Address _____

Dates of Confinement _____

Have you consulted any other physicians or been hospitalized in the past three years? □ ***Yes*** □ ***No*** ***If "Yes," complete the following concerning your past treatment (attach separate sheet, if needed)***

Doctor's Name _____Telephone _____

Specialty _____ Fax _____

Address _____

Dates seen_____

Hospital _____

Address _____

Dates of Confinement _____

Statement for Long Term Disability Income Benefits

F. Other Income

Check the other income benefits you have received, are receiving, or are eligible to receive during your disability (complete the information requested).

Source of Income	*Amount(week/month)*	*Date Claim was filed*	*Date Payments began*	*Date Payments ended*
Social Security/Retirement	$ _____	_____	_____	_____
Social Security/Disability	$ _____	_____	_____	_____
Sick Pay or Salary Continuation	$ _____	_____	_____	_____
Income from Work	$ _____	_____	_____	_____
Workers' Compensation	$ _____	_____	_____	_____
State Disability	$ _____	_____	_____	_____
Pension/Retirement	$ _____	_____	_____	_____
Pension/Disability	$ _____	_____	_____	_____
Short Term Disability	$ _____	_____	_____	_____
Unemployment	$ _____	_____	_____	_____
No-Fault Insurance	$ _____	_____	_____	_____
Other (*include Individual or Group benefits*)	$ _____	_____	_____	_____

G. Information about Tax Withholding

Federal law requires us to withhold federal income tax from your check **if you request us to do so**. We are also required to send a report to your employer at the end of each calendar year showing your name, total amount of benefits paid to you, total amount withheld, if any, and your social security number. If you want us to withhold tax, please indicate on the line below the dollar amount to be withheld per benefit check. Whole dollars only (minimum is $88.00 per month): $_____.00. **IMPORTANT:** If you pay the entire cost of the LTD premium, but on a Post-tax basis per Section I, Part D of the Employer's Statement, you will not be able to request any federal income tax withholding from your check. Puerto Rico residents may not request withholding.

Note to residents of Iowa and the District of Columbia: Should you choose federal income tax withholding, your state requires us to withhold state income tax. We must withhold at a state mandated rate (which may be higher than you need) until we receive a signed state Tax Withholding Certificate from you. Please contact your employer or state Tax Department to obtain the proper withholding form.

Note to residents of Nebraska, Rhode Island and South Carolina: Should you choose federal income tax withholding, your state requires us to withhold state income tax. We must withhold at a state mandated rate (which may be higher than you need) until we receive a signed federal Form W-4, Employee's Withholding Allowance Certificate, from you. You may go to www.irs.gov to obtain the proper withholding form.

H. Signature **- Please read the statement that applies to your state of residence and sign the bottom of the page.**

With the exception of any source(s) of income reported above in Section F of this form, I certify by my signature that I have not received and am not eligible to receive any source of income, except for my Disability Income. Further, I understand that should I receive income of any kind or perform work of any kind during any period Kanawha Insurance Company has approved my disability claim, I must report all details to Kanawha Insurance Company, immediately.

If I receive disability benefits greater than those which should have been paid, I understand that I will be required to provide a lump sum repayment to the insurance company. The insurance company has the option to reduce or eliminate future disability payments in order to recover any overpayment balance that is not reimbursed.

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

Statement for Long Term Disability Income Benefits

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 a 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 resident s 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, 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 and denial of insurance benefits.

For residents of New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information 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 Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit and 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 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 thereto that the insurer relied upon 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.

The statements contained in this form are true and complete to the best of my knowledge and belief.

Signature of the employee _____ Date _____

Please attach a copy of your Driver's License or another document that verifies your date of birth.

Statement for Long Term Disability Income Benefits

Authorization to Obtain and Disclose Information — Section III

To: Any health care provider, employer, benefit plan, insurer, service provider, financial institution, consumer reporting agency, educational institution, or Federal, State, or Local Government Agency, including the Social Security Administration and Veterans Administration. **I AUTHORIZE** you to disclose to Kanawha Insurance Company a complete copy of any and all of the following personal or privileged information, records, or documents relative to:

_____ _____ _____

Insured's Name *(please print)* Date of Birth Last 4 Digits of Social Security Number

Any and all medical information or records, including x-ray films, medical histories, physical, mental, or diagnostic examinations, and treatment notes, and including information regarding HIV/AIDS, communicable diseases, alcohol or drug abuse, and mental health; work information and history, including job duties, earnings, personnel records, and client lists; information on any insurance coverage and claims filed, including all records and information related to such coverage and claims; credit information, including credit reports and credit applications; other financial information, including pension benefits and bank records; business transactions billing, invoice, and payment records; academic transcripts; and information concerning Social Security 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 for the purpose of evaluating and administering my claim for benefits and/or leave request. Such information shall be referred to herein collectively as "My Information." I understand I have the right to revoke this Authorization for future disclosures, except to the extent action has been taken in reliance upon this Authorization. I must revoke this Authorization in writing directly to Kanawha Insurance Company.

I UNDERSTAND that once My Information has been disclosed to Kanawha Insurance Company as permitted under this Authorization, it maybe re-disclosed by Kanawha Insurance Company as permitted by law or my further authorization. I authorize Kanawha Insurance Company to use or disclose My Information (i) to my employer for a) functions related to accommodating my disability; b) responding to claims related to accommodation or adverse or discriminatory treatment related to my claim; c) responding to complaints by me or my representative relating to benefits or leave; d) responding to any litigation or agency document production request or lawful subpoena; e) federal, state, or other leave administration; f) fulfilling fiduciary obligations under my benefit plan; or (g)claim or other audits or reviews; (ii) to the administrator or other service providers of my employer's benefit plan, other benefits, and/or leave programs of my employer for plan, benefit, or program related functions or data aggregation and analysis; (iii) to any claim system used for claims processing or insurance broker to carry out functions related to my benefit plan 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; (vii) as may be lawfully required; (viii) as may be reasonably necessary to protect the personal safety of others; or (ix) as may be reasonably necessary to prevent or detect perpetration of a fraud.

Statement for Long Term Disability Income Benefits

I ALSO UNDERSTAND that information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient. I understand that I have the right to revoke this Authorization for future disclosures Kanawha Insurance Company may make, unless Kanawha Insurance Company has taken action in reliance upon this Authorization. I must revoke this Authorization in writing directly to Kanawha Insurance Company. I understand that my medical treatment or payment for medical benefits cannot be conditioned on my allowing Kanawha Insurance Company to re-disclose My Information. 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 or protect the personal safety of others. I understand that I am entitled to receive a copy of this Authorization upon request. A photocopy or facsimile of this Authorization shall be as valid as the original. If there is a conflict between a prior request for restriction on the disclosure of My Information and this Authorization, this Authorization will control.

Signature of Insured or Guardian _____

Relationship to Insured (if signed by Guardian) _____

Date _____

Statement for Long Term Disability Income Benefits

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Attending Physician's Statement — Section IV

To be completed by the Employee

Patient's Name _____ Social Security Number _____ Date of Birth _____

Address _____

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

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

Patient's condition is the result of □ Illness □ Injury □ Pregnancy

Height_____ Weight_____ If pregnancy, what is the expected date of delivery? _____

Is condition due to an illness or an injury that is work related? □ Yes □ No

Diagnosis

Primary diagnosis _____ ICD-9 Code _____

Secondary diagnosis(es)_____ ICD-9 Code(s) _____

Subjective Symptoms _____

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

Test _____Date_____Results_____

Test _____Date_____Results_____

Physical examination findings _____

_____

If pregnancy, indicate LMP date _____

Treatments

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

Date of onset of this condition? _____ 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, address and specialty_____

_____

Nature of treatment for this condition_____

_____

Was surgery 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

Statement for Long Term Disability Income Benefits

Attending Physician's Statement of Disability (continued)

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.

Date patient ceased work due to this impairment: _____

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

Attending Physician's Name _____ Telephone_____

License Number _____ Fax _____

SS# or E.I.N. # _____ Degree _____Specialty _____

Address _____

Signature _____ Date Signed _____