

# 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 - page 4.
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:**  
**gbclaimspw@thehartford.com**

For questions about how  
to complete this form call  
The Hartford Toll-free at:  
**1-888-563-1124**

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

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



## 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: <input type="checkbox"/> Full time <input type="checkbox"/> Part time	Date Group Life Insurance became effective:	Last day worked:	Premiums paid to date? <input type="checkbox"/> Yes <input type="checkbox"/> No
Employee Division	<input type="checkbox"/> Exempt	<input type="checkbox"/> Non-exempt	<input type="checkbox"/> Salaried <input type="checkbox"/> Hourly
<b>Group Life:</b> Insurance coverage amount: <b>Basic Life \$</b> _____		<b>Supplemental Life \$</b> _____ (Attach enrollment forms & beneficiary form.)	
<b>Permanent Total Disability Benefits:</b>			
Amount of <b>Basic Life</b> Insurance \$ _____		Amount of <b>Supplemental Life</b> Insurance \$ _____	
Amount of Permanent Total Disability requested \$ _____		Number of hours scheduled to work weekly _____	
Rate of Annual Basic Earnings on date last worked: \$ _____ per <input type="checkbox"/> Hour <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year (Attach W-2, if applicable)			
Do earnings include commissions, bonuses or overtime? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," please specify:			
Are employee's eligible dependents covered by Waiver of Premium or Disability Extension benefits? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," date: _____			
Was an application for conversion offered? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is your employee receiving income from other sources? e.g.: <input type="checkbox"/> Short Term Disability <input type="checkbox"/> Long Term Disability <input type="checkbox"/> Workers' Compensation <input type="checkbox"/> 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 \_\_\_\_\_ College \_\_\_\_\_  Masters  Ph.D.  
1 2 3 4 1 2 3 4 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 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 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**

**To:** Any health care provider, pharmaceutical provider, pharmacy benefits manager, employer, benefit plan, insurer, service provider, financial institution, educational institution, or Federal, State, or Local Government Agency, including the Social Security Administration and Veterans Administration. **I AUTHORIZE** you to disclose to The Hartford<sup>1</sup> a complete copy of, and to communicate telephonically or electronically with The Hartford's representatives about, any and all of the following personal, private, 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 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 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 and/or request for accommodation. 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 The Hartford.

**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 or adverse or discriminatory treatment related to my claim or condition; c) responding to complaints by me or my representative relating to benefits or 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 or other audits or reviews; (ii) to the administrator 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 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; (ix) as may be reasonably necessary to respond to regulatory complaints; and (x) as may be reasonably necessary to prevent or detect perpetration of a fraud.

**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 The Hartford may make, unless The Hartford has taken action in reliance upon this Authorization. I must revoke this Authorization in writing directly to The Hartford. I understand that my medical treatment or payment for medical benefits cannot be conditioned on my allowing The Hartford 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, respond to regulatory complaints, 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  
Authorized Representative

\_\_\_\_\_  
Date (Valid for 2 years)

\_\_\_\_\_  
Relationship to Insured  
(if signed by Authorized Representative)

<sup>1</sup>The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries and their affiliates



Please fax the completed form to:

Fax Number: 877-467-3037

The Hartford

P.O. Box 14296

Lexington, KY 40512-4296

ATTENDING PHYSICIAN'S STATEMENT - INITIAL REPORT



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

[ ] Y [ ] T

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:

The Hartford® is underwriting companies Hartford Life and Accident Insurance Company and Hartford Life Insurance Company. The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries.

Patient Name:

Date of Birth:

Insured ID Number:

Complete this section to the best of your ability. Comments such as % or ^ are not allowed.

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	or	Intermittently with standard breaks	If intermittent circle time for each section below															
				Hours at one time								Total hours/8 hours							
Sit	<input type="checkbox"/>		<input type="checkbox"/>	1	2	3	4	5	6	7	8	1	2	3	4	5	6	7	8
Stand	<input type="checkbox"/>		<input type="checkbox"/>	1	2	3	4	5	6	7	8	1	2	3	4	5	6	7	8
Walk	<input type="checkbox"/>		<input type="checkbox"/>	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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Kneel/crouch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Climb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Balance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Drive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Lift - Indicate weight in pounds		_____ lbs.	_____ lbs.	_____ lbs.	
Other Restrictions (if any)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Hand Dominance:  Right  Left

Upper Extremity Activity (not load bearing) Specify right (R) or left (L) if not bilateral

Fine manipulation (fingering, keyboard)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Gross manipulation (grip/grasp, handle)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Reach (extend arms) above shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Reach (extend arms) below shoulder at desk or workbench level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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: \_\_\_\_\_