

Disability Claim



CIGNA Group Insurance

Life • Accident • Disability

Life Insurance Company of North America

Connecticut General Life Insurance Company

CIGNA Life Insurance Company of New York

GB-608066 (08/2003)

FRAUD WARNING: Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act. For residents of the following states, please see the reverse side: **California, Colorado, District of Columbia, Florida, Maryland, New Jersey, New York, Pennsylvania, Oregon or Virginia.**

ATTENDING PHYSICIAN'S STATEMENT OF DISABILITY (PLEASE PRINT)

The insured is responsible for having this form completed by any/all treating physician(s) without expense to the company. We must have comprehensive medical information in order to evaluate the insured's claim for Disability Benefits.

THIS SECTION IS TO BE COMPLETED BY THE PATIENT/INSURED		
1. NAME	EMPLOYER NAME	
ADDRESS	SOCIAL SECURITY NUMBER	
CITY	STATE	ZIP CODE
TELEPHONE	OCCUPATION	GROUP POLICY NUMBER
		DATE OF BIRTH

THE REMAINING SECTIONS OF THIS FORM ARE TO BE COMPLETED BY YOUR PHYSICIAN(S)

1.	<p>DIAGNOSIS (Including any complications)</p> <p>(a) Diagnosis (Include ICD-9 or DSM-IV Code)</p> <p>(b) Subjective symptoms</p> <p>(c) Objective findings (Please attach copies of current X-rays, EKG's, Laboratory Data and any clinical findings as applicable.)</p> <p>(d) Are symptoms consistent with the clinical findings? <input type="checkbox"/> Yes <input type="checkbox"/> No, explain _____</p> <p>(e) Is illness work related? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(f) If pregnancy please indicate: LMP: _____ EDC: _____ Actual Delivery: _____</p>
2.	<p>DATES OF TREATMENT</p> <p>• Date patient first visited you for this accident/illness: _____ <i>Month Day Year</i></p> <p>• Date patient first unable to work due to this accident/illness: _____ <i>Month Day Year</i></p> <p>• List frequency & date(s) patient was examined for this accident/illness: _____</p> <p>• Date of last visit: _____ <i>Month Day Year</i></p>
3.	<p>NATURE OF TREATMENT (Including Surgery & Medications prescribed, if any)</p> <p>Hospitalization on: _____ <i>Month Day Year</i> THROUGH _____ <i>Month Day Year</i></p> <p>• Surgery on: _____ Type of Surgery: _____</p> <p>Name and Address of Hospital</p> <p>_____</p> <p>• Medications-type/dosage:</p> <p>_____</p> <p>• Medications-type/dosage:</p> <p>_____</p>

4. PHYSICAL LIMITATIONS / IF APPLICABLE: In an 8 hour day is your patient able to:

	0 hours	up to 2.5 hours	up to 5.5 hours	greater than 5.5 hours	
Climb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cardiac - If applicable (American Heart Association) <input type="checkbox"/> Class 1 - No Limitation <input type="checkbox"/> Class 2 - Slight Limitation <input type="checkbox"/> Class 3 - Marked Limitation <input type="checkbox"/> Class 4 - Complete Limitation Blood Pressure (last visit) _____
Balance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Stoop	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Kneel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Crouch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Crawl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Reach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Walk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Stand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Please indicate the maximum level of ability (sedentary, light, medium, heavy) of your patient to:

_____ Lift _____ Carry _____ Push _____ Pull _____

Sedentary = 10 lbs. maximum, walking occasionally. **Light** = 20 lbs. maximum, 10 lbs. frequently

Medium = 50 lbs. maximum, 25 lbs. frequently, up to 10 lbs. constantly. **Heavy** - 100 lbs. maximum, 50 lbs. frequently, 20 lbs. constantly.

5. MENTAL IMPAIRMENT / IF APPLICABLE: Please complete the following (incomplete information will delay claim processing):

Axis I: _____

II: _____

III: _____

IV: _____

V: Current GAF: _____ Highest GAF in past year: _____

Additional Comments:

6. EXTENT OF DISABILITY

	Patient's Regular Occupation	Any Occupation
When was patient able to go to work?	Month Day Year	Month Day Year

7. REHABILITATION

(a) Is patient a suitable candidate for further PHYSICAL / PSYCHOLOGICAL rehabilitation services? Yes No

If no, explain: _____

(b) Can present job be modified to allow for handling with impairment?

(c) Is patient a suitable candidate for **VOCATIONAL** rehabilitation services?

If no, when: _____

8. REMARKS

DATE	PRINT NAME (ATTENDING PHYSICIAN)	SIGNATURE	DEGREE
TELEPHONE NUMBER		PROVIDER TAX ID NUMBER	
STREET ADDRESS			
CITY OR TOWN		STATE (OR PROVINCE)	ZIP CODE

IMPORTANT CLAIM NOTICE

California Residents: For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado Residents: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

District of Columbia Residents: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida Residents: 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.

Maryland Residents: Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any fact material thereto, may be committing a fraudulent insurance act.

New Jersey Residents: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New York Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed \$5000 and the stated value of the claim for each such violation.

Pennsylvania Residents: Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Oregon Residents: Any person who knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or, (2) conceals for the purpose of misleading, information concerning any material fact, may have committed a fraudulent insurance act.

Virginia Residents: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits application or files a claim containing a false or deceptive statement may have violated state law.