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

INSTRUCTION PAGE

Claim form to waive premium on Group Life Insurance for covered employees who have become disabled and are unable to work.

Why apply for Group Life Waiver of Premium?

If employees become 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. ****Reminder** 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. Detach and complete the Employer Section. Sign and date the Employer's Section. Without this information, the claim process 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 elections.

3. Attach a copy of the most recent Beneficiary Designation Form.

4. Give the remaining sections of the form, including this instruction sheet, to your employee. Ask him or her to complete the Employee Sections and return the claim form to The Hartford. (Your employee should detach the *Attending Physician's Statement of Disability,* Attending Physician's Statement, pages 1 through 4, and forward to his/her physician for completion.)

5. SUBMIT THE EMPLOYER'S STATEMENT & ATTACHMENTS DIRECTLY TO THE HARTFORD BEFORE THE 12-MONTH DEADLINE.

EMPLOYEE'S RESPONSIBILITY - SECTION 2

1. Complete Employee Section - pages 1 and 2. Sign and date the claim form on Employee Section - page 3.

2. Read and complete Employee Section 2 - page 4. Sign and date the authorization at the bottom of the Employee Section 2 - page 4.

3. On the *Attending Physician's Statement of Disability*, complete and sign the Employee information and authorization at the top of the Attending Physician's Statement - page 1. Remove the *Attending Physician's Statement of Disability Section* (Attending Physician's Statement) - pages 1 through 4 from this claim form and give it to the physician certifying your disability. Ask your physician to complete the form and return it within 10 days to The Hartford. Be aware that you are responsible for any fees charged by your physician for completion of this form.

4. SUBMIT THIS APPLICATION BEFORE THE 12-MONTH DEADLINE* To qualify for benefits, submit the completed Employee Sections and all attachments, by the deadline* specified in your Group Life plan. Make a copy to keep with your records. The *Attending Physician's Statement* should be sent separately by the physician before the same deadline. The Employer section should be sent separately before the same deadline.

5. Please follow up to make sure that this claim form, all attachments, and the *Attending Physician's Statement of Disability* are received by The Hartford within the deadline* specified in your Group Life plan.

SEND THE CLAIM FORM TO:

THE HARTFORD
Group Life Claims
P. O. Box 2999
Hartford, CT 06104-2999

OR FAX TO:

Group Life Claims
1-860-843-4713

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

***The deadline for submission is usually 12 months from the employee's last day of work; check your plan to be sure.** Coverages underwritten by Hartford Life Insurance Company, Hartford Life Insurance Company or Hartford Life and Accident Insurance Company.

Clear Form

EMPLOYER SECTION I
This is a time-sensitive document
***Submission deadline is usually 12 months from the last day of work; check your plan.**

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

THE HARTFORD

A. INFORMATION ABOUT YOUR COMPANY

Company Name: CBIA Service Corp.

Address (Street, City, State, Zip Code)

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

Group Policy Number	Tele Phone Number	Fax Number	E-Mail address
GRH703586/677347	( )	( )	

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: _____

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 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? _____ | Why did employee stop working? _____

Date employee is expected to, or did return to work: _____ Full time? ☐ Yes ☐ No

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

EMPLOYEE SECTION 2
This is a time-sensitive document
***Submission deadline is usually 12 months from the last day of work; check your plan.**

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

THE HARTFORD

Group Policy # GRH-703586, GRH-677347

Employer Name: CBIA Service Corp.

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

A. INFORMATION ABOUT YOU

Name:

Address:

Telephone Number: ( ) | ☐ Male ☐ Female | E-Mail address:

At the time 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 the dates when you worked (or were selfemployed).

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 ( )

E. EMPLOYEE'S SIGNATURE

For residents of all states *EXCEPT* California, Florida, New Jersey, Colorado, Pennsylvania, Arkansas, New Mexico, Louisiana, New York, Virginia and Puerto Rico: A person commits a fraudulent insurance act if that person knowingly, and with intent to defraud any insurance company or other person, either: (a) files an application for insurance or statement of claim containing any materially false information, or (b) Insurance policy. **A fraudulent insurance act is a crime.** (In Oregon, a fraudulent insurance act may be a crime.) The Hartford shall pursue prosecution of any fraudulent insurance act to the fullest extent of the law.

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 New Jersey, Arkansas, and New Mexico: 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 an insurance policy is subject to criminal and civil penalties.

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 thereto commits a fraudulent insurance act, which is a crime and subjects a person to criminal and civil penalties.

For residents of Colorado: It is unlawful to knowingly provide false, incomplete, or misleading 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 its agent who knowingly provides false, incomplete, or misleading information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to an insurance settlement or award shall be reported to the Colorado Division of Insurance.

FOR RESIDENTS OF CALIFORNIA: 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."

For residents of Louisiana: 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 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 Puerto Rico: Any person who knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

For residents of Virginia: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

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 of Employee _____ **Date** _____

RETURN COMPLETED EMPLOYEE STATEMENT TO:

THE HARTFORD
Group Life Claims
P. O. Box 2999
Hartford, CT 06104-2999

OR FAX TO:

Group Life Claims
1-860-843-4713

Authorization to Obtain and Release Information

TO: Any physician, medical practitioner, hospital, pharmacy, clinic or other medical or medically-related facility or provider of medical or dental services or supplies who has provided payment, treatment or services to me or on my behalf within the last 10 years;

any Federal, State or Local Government Agency, including Social Security Administration and Veterans Administration;

any past or present employer;

Any group insurance policyholder, insurance contract holder, insurance company or reinsurance company, benefit plan administrator, claims administrator that has provided payment or services to me or on my behalf within the last 10 years and Insurance Services, Office, Inc.

I have filed a claim for insurance services under a group life, accidental death and dismemberment and/or disability income policy issued by Hartford Fire Insurance Company, Hartford Life Insurance Company and/or Hartford Life and Accident Insurance Company. This authorization is intended to comply with the requirements of §164.508(c) of the Standards for the Privacy of Individually Identifiable Health Information under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") effective April 14, 2003. However, by signing this Authorization, I understand that Hartford Fire Insurance Company, Hartford Life Insurance Company, Hartford Life and Accident Insurance Company and their affiliates, employees, representatives and agents ("collectively "Hartford") are not subject to the requirements of HIPAA. Hartford will use information received in accordance with this Authorization for the purpose of evaluating and administering claims for group life, accidental death and dismemberment and/or disability income benefits.

By signing this Authorization, I authorize you to release and disclose to Hartford, a complete copy of any and all health information, including but not limited to x-rays, photocopies of medical records, medical histories, physical, mental or diagnostic examinations, and treatment notes (collectively "Health Information"). For purposes of this Authorization, Health information specifically includes confidential information regarding HIV/AIDS; sexually transmitted diseases and communicable diseases, alcohol or drug use, and treatment of mental illness but excludes psychotherapy notes as defined by HIPAA.

By signing this Authorization, I acknowledge and agree that any agreements I have made to restrict disclosure of my Health information do not apply to this Authorization and I authorize any person or entity identified above to release and disclose my complete medical file without restriction.

Claimant's Name: _____ Social Security Number: _____

By signing this Authorization, I acknowledge that I understand the following:

- That any Health Information disclosed under this Authorization may no longer be protected by the federal privacy standards under HIPAA and may be re-disclosed without the knowledge of any person or entity authorized to disclose the Health information. Note that Hartford will only use Health information obtained under this Authorization for the purpose of evaluating and administering claims for group life, accidental death and dismemberment and/or disability income benefits, including obtaining reinsurance and conducting legal and business activities that relate to such claims. Hartford will only disclose Health Information obtained under this Authorization in accordance with its Corporate Privacy Policy.
- That my claim for benefits may be delayed and/or denied if Hartford is unable to obtain Health information necessary to properly assess my claim because I do not properly sign, date, and deliver this authorization or any person subject to HIPAA that receives it does not comply with it.
- That, if necessary, Hartford will send this authorization to persons or entities authorized to release Health Information about me. I have a right, at any time, to revoke this authorization by submitting a written request directly to such persons or entities. My revocation will not be effective to the extent that action has been taken in reliance upon this Authorization or Hartford otherwise has the right to contest the policy or claim under the policy.
- That this authorization will expire (2) years from the date of my signature.
- That a photographic copy of this Authorization shall be as valid as the original and I am entitled to a signed copy of this authorization.

_____ _____

Signature of Claimant or Personal Representative Date

_____

Description of Personal Representative's Authority or Relation to Insured (Required if Signed by Personal Representative)

ATTENDING PHYSICIAN'S STATEMENT
This is a time-sensitive document

Submission deadline is usually 12 months from the last day of work; check your plan.

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

The employee is responsible for any physician fees for the completion of this form.
This section to be completed and signed by the Employee

Name of Patient

Address (Street, City State & Zip Code)

Telephone Number ( )

Date of Birth

Social Security Number

Employer and Division *(if applicable)*

I hereby authorize my physician to release any information concerning my medical condition(s) for the purpose of claim processing.

Patient's Signature

Date

Physician's Instructions **Please respond within 10 Days**

A delay in returning a completed *Attending Physician's Statement* could result in your patient's being disqualified from receiving valuable Life Insurance benefits.

Please complete the remainder of this form for your patient. Sign and date the last page.

SEND THE COMPLETED FORM TO:
THE HARTFORD
Group Life Claims
P. O. Box 2999
Hartford, CT 06104-2999

OR FAX TO:
Group Life Claims
1-860-843-4713

If you have questions, call The Hartford Toll-free at 1-800-303-9744

This section to be completed by the Attending Physician

A. PATIENT INFORMATION

Height _____ Weight _____

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

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

B. DIAGNOSIS

Primary diagnosis _____ ICD-9 Code _____

Secondary diagnosis(es) _____ ICD-9 Code _____

Concurrent/Co-morbid conditions(s) _____ ICD-9 Code _____

Subjective symptoms: _____

Objective findings: _____

C. TREATMENTS

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

Date Patient was first advised to stop working due to Illness/Injury _____

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

How often has patient been seen or treated? _____ Date of next office visit. _____

Has patient been referred to any other physician? ☐ Yes ☐ No
If "Yes":

Physician's name _____ Physician's Telephone Number (____) _____

Physician's address _____

Specialty _____ Date of office visit _____

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,"

Name and address of hospital(s) _____

Date(s) admitted _____ Date(s) discharged _____

Progress (please check one) ☐ Recovered ☐ Improved ☐ Unchanged ☐ Retrogressed

D. PHYSICAL IMPAIRMENTS

1. Indicate the extent to which the patient's ability to perform any of the following activities is limited by his or her disorder. In an 8-hour workday, the patient can *(Circle or check number of hours)*:

Sit for 0 1 2 3 4 5 6 7 8 hours at a time Stand for 0 1 2 3 4 5 6 7 8 hours at a time

Walk for 0 1 2 3 4 5 6 7 8 hours at a time Drive for 0 1 2 3 4 5 6 7 8 hours at a time

2. Check the maximum limit and frequency that the patient can lift/carry:

	Never	Occasionally	Frequently	Constantly
1-10 lbs.	☐	☐	☐	☐
11-20 lbs.	☐	☐	☐	☐
21-50 lbs.	☐	☐	☐	☐
51-100 lbs.	☐	☐	☐	☐
over 100 lbs.	☐	☐	☐	☐

D. PHYSICAL IMPAIRMENTS (cont'd)

3. Check the maximum limit and frequency that the patient can lift/carry:

	Never	Occasionally	Frequently	Constantly
Climbing	☐	☐	☐	☐
Balancing	☐	☐	☐	☐
Stooping	☐	☐	☐	☐
Kneeling	☐	☐	☐	☐
Crouching	☐	☐	☐	☐
Crawling	☐	☐	☐	☐
Reaching				
Above shoulder	☐	☐	☐	☐
Below waist level	☐	☐	☐	☐
At waist level	☐	☐	☐	☐
Handling	☐	☐	☐	☐
Fingering	☐	☐	☐	☐
Feeling	☐	☐	☐	☐

4. Indicate the patient's capacity for repetitive use of feet and hands.

Right hand ☐ Yes ☐ No Left hand ☐ Yes ☐ No Both hands ☐ Yes ☐ No

Right foot ☐ Yes ☐ No Left foot ☐ Yes ☐ No Both feet ☐ Yes ☐ No

4a. Dominant hand (check one) ☐ Right ☐ Left

5. If any other activities are limited, please specify the activities and the limitations

6. If the patient's vision is impaired, please describe the extent of the impairment _____

Date vision test was performed _____ Visual Acuity:

	R	L
Corrected		
Non-Corrected		

7. From the following classifications of work strength requirements, please describe the exact degree of work you feel this patient is capable of performing*: _____

☐ **Sedentary Work:** Lifting 10 lbs. maximum and occasionally lifting and/or carrying articles such as dockets, ledgers and small tools. A job is considered sedentary if it involves primarily sitting, and requires only occasional walking and standing.

☐ **Light Work:** Lifting 20 lbs. with frequent lifting and/or carrying of objects weighing up to 10 lbs. A job is considered Light Work if it involves sitting most of the time with a degree of pushing and pulling or use of arm and/or arm controls; or when it requires walking or standing to a significant degree.

☐ **Medium Work:** Lifting 50 lbs. maximum with frequent lifting and/or carrying of objects weighing up to 25 lbs.

☐ **Heavy Work:** Lifting 100 lbs. maximum with frequent lifting and/or carrying of objects weighing up to 50 lbs.

☐ **Very Heavy Work:** Lifting more than 100 lbs. with frequent lifting and/or carrying of objects weighing 50 lbs or more.

***Five degrees of work are taken from the Dictionary of Occupational Titles, Volume II, pages 654-655, published by the U.S. Dept of Labor (3rd ed. 1965)**

8. Are there environmental workplace restrictions for this patient as a result of the patient's impairment? ☐ Yes ☐ No
"If Yes," describe:

9. CARDIAC (complete if disability is due to heart condition) ☐ Class 1 (No limitation) ☐ Class 2 (Slight limitation)
☐ Class 3 (Marked limitation) ☐ Class 4 (Complete limitations)

Remarks: _____

E. PSYCHIATRIC IMPAIRMENTS (if applicable)

What problems with stress or interpersonal relations has the patient had on the job? Indicate the degree to which the patient is able to perform the duties of their occupation.

☐ **Class 1 - No Limitations:** Patient is able to function under stress and engage in interpersonal relations.

☐ **Class 2 - Slight Limitations:** Patient is able to function in most stress situations and engage in only limited interpersonal relations.

☐ **Class 3 - Moderate Limitations:** Patient is able to engage in stress situations or engage in only limited interpersonal relations.

☐ **Class 4 - Marked Limitations:** Patient is unable to engage in stress situations or engage in interpersonal relations.

☐ **Class 5 - Severe Limitations:** Patient has significant loss of psychological, physiological, personal and social adjustment.

Do you believe the patient is competent to endorse checks and manage the proceeds appropriatley? ☐ Yes ☐ No

Remarks: _____

_____

GAF Score: _____ Date: _____

What are the stressors? _____

Job Related? ☐ Yes ☐ No

F. OUTLOOK

Has the patient reached maximum medical improvement ☐ Yes ☐ No

Date patient can return to work at his/her regular job: _____
Month Day Year

Specify: ☐ Without restrictions
☐ With restrictions, as noted

Date patient can return to work at a different job in a lighter duty capacity _____
Month Day Year

How long do you expect the restrictions and limitations from any work to continue? _____

G. PHYSICIAN INFORMATION

_____ _____
Physician's Name: Social Security Number or EIN

_____
Address: *(Street, City, State, Zip Code)*

_____ _____ ( ) _____ ( ) _____
Specialty Licence Number Telephone Number Fax Number

_____ _____
Physician's Signature Date

PLEASE ATTACH OFFICE NOTES, CONSULTATION REPORTS, OR ANY DIAGNOSTIC TESTS THAT ILLUSTRATE CURRENT LIMITATIONS AND RESTRICTIONS.