



## Group Disability

Submit to:  
**Aetna U.S. Healthcare**  
**Life Insurance Service Center**  
**151 Farmington Avenue**  
**Hartford, CT 06156-7320**

- Employee completes Sections 1 - 3.
- Employer completes Section 4.

- Please submit this form along with completed Attending Physician Statement to the above address.

<b>1. Employee Information</b>	Employer Name (1)	Branch (2)	
	Employee Name (3)	Birthdate (mm/dd/yyyy) (4)	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female (5)
	Address (street, city, state, zip code) (6)		Daytime Telephone Number ( ) (7)
	Occupation (8)	Cause of Disability (9)	

<b>2. Attending Physician Information</b> <i>List the physician(s) now attending you. (Use back if more space is needed)</i>	Physician's Name (1)	Physician's Address (2)	Condition Treated (3)

**3. Release**

To all providers of health care:  
 You are authorized to provide Aetna Life Insurance Company or one of its affiliated companies ("Aetna"), and any independent claim administrators and consulting health professionals and utilization review organizations with whom Aetna has contracted, information concerning health care advice, treatment or supplies provided the patient (including that relating to mental illness and/or AIDS/ARC/HIV). This information will be used to evaluate claims for benefits. Aetna may provide the employer named above with any benefit calculation used in payment of this claim for the purpose of reviewing the experience and operation of the policy or contract. This authorization is valid for the term of the policy or contract under which a claim has been submitted. I know that I have a right to receive a copy of this authorization upon request and agree that a photographic copy of this authorization is as valid as the original.

Patient's or Authorized Person's Signature \_\_\_\_\_ (1) Date \_\_\_\_\_ (2)

<b>4. Employer Information</b>	Control Number (1)	Control Suffix (2)	Claim Account (3)	Social Security Number - - (4)
	Employee is <input type="checkbox"/> Hourly <input type="checkbox"/> Salary (5)	Amount of Insurance in Force on Date Last Worked \$ (6)	Rate of Basic Earnings on Date Last Worked \$ _____ (7) <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Annually	
	Reason Employee Did Not Return to Work After Last Day Worked (8)			Date Last Worked (9)
	Effective Date Insurance Discontinued if Not in Force (10)			
	Type of Coverage <input type="checkbox"/> DBO-AID <input type="checkbox"/> Premium Waiver <input type="checkbox"/> PTD (check one): <input type="checkbox"/> Installment, provide terms _____ (11) Months <input type="checkbox"/> Lump Sum		Date Employee First Began Work (12)	Date Insurance Took Effect (13)
	Was employee required to submit evidence of insurability? <input type="checkbox"/> No <input type="checkbox"/> Yes, give date submitted _____ (14)		Rate of Basic Earnings on Date Last Worked (complete only if employee elected Paid-up Coverage) \$ _____ Contributions from last renewal date \$ _____ Contributions for policy year prior to last renewal date	
	Last Contribution Covered Period Ending (complete only if employee contributed part of premium) (16)		Contributions should cease upon completion of this form if policy is Paid-up Insurance. If contributions are for Term Insurance only, check one of the following: <input type="checkbox"/> Term <input type="checkbox"/> Permanent (15)	
	Employer's Address (street, city, state, zip code) (17)			Telephone Number ( ) (18)
Signature of Employer's Authorized Representative (19)			Date (20)	

For your protection, California law requires notice of the following: Any person who knowingly and with intent to defraud or deceive any insurance company files a statement of claim containing any materially false, incomplete or misleading information is guilty of a crime and may be subject to fines, confinement in a state prison, and substantial civil penalties. Many other states have similar laws. Attention Colorado Residents: An insurer or agent who knowingly provides false or misleading information to defraud a claimant regarding insurance proceeds must be reported to the Insurance Division.

40-005  
 GC-9007 (12-98) AIFS

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***Disability Claims — Attending Physician's Statement Form***

The employee should complete the Patient Information and the Employer Information section before giving the form to his/her physician. The remaining sections, 1 - 10 and the Remarks section are to be completed by the physician who is primarily responsible for the care and treatment of the employee.

If you have any questions concerning the information we are requesting, call the toll-free number for the Aetna U.S. Healthcare — Life Insurance Service Center shown in the Customer Service Information section of this manual.



## Attending Physician's Statement

Complete this form in full.

The patient is responsible for completion of this form without expense to the company.

You may use the Remarks section on the reverse side if you need more room to respond.

<b>Patient Information</b>	Name (First, Middle Initial, Last) _____	Social Security Number _____	Birthdate _____
	Address (include No. Street, Town, State, Zip Code) <input type="checkbox"/> Address is new _____		
<b>Employer Information</b>	Name _____		
<b>1. History</b>	(a) Height _____ Weight _____ (b) Date symptoms first appeared or accident happened ..... Mo. _____ Day _____ Year _____ (c) Date patient ceased work because of disability ..... Mo. _____ Day _____ Year _____ (d) Has patient ever had same or similar condition? <input type="checkbox"/> No <input type="checkbox"/> Yes, state when and describe. (e) Is condition due to injury or sickness arising out of patient's employment? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown (f) Names and addresses of other treating physicians Name _____ Address _____ Name _____ Address _____ Name _____ Address _____		
<b>2. Diagnosis</b>	(a) Date of last examination ..... Mo. _____ Day _____ Year _____ (b) ICD diagnostic code (mandatory) _____ (c) Diagnosis (including any complications) _____ (d) Subjective symptoms _____ (e) Objective findings (including current X-rays, EKG's, laboratory data and any clinical findings): (1.) Clinical Findings: _____ (2.) Diagnostic Studies and Results: _____ (f) If disability is due to pregnancy, the expected delivery date is ..... Mo. _____ Day _____ Year _____ (g) Other disease or infirmity affecting present condition _____		
<b>3. Dates of Treatment</b>	(a) Date of first visit ..... Mo. _____ Day _____ Year _____ (b) Date of last visit ..... Mo. _____ Day _____ Year _____ (c) Frequency ..... <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other (specify) _____ (d) Is patient still under your care for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No, indicate date service terminated _____		
<b>4. Nature of Treatment</b>	(a) Type and dates of treatment: (b) Prescribed medications: (c) Surgical procedures and dates:		
<b>5. Progress</b>	(a) Patient has ..... <input type="checkbox"/> Recovered <input type="checkbox"/> Improved <input type="checkbox"/> Stabilized <input type="checkbox"/> Retrogressed (b) Patient is ..... <input type="checkbox"/> Ambulatory <input type="checkbox"/> House confined <input type="checkbox"/> Bed confined <input type="checkbox"/> Hospital confined (c) Has patient been hospital confined? <input type="checkbox"/> No <input type="checkbox"/> Yes, give name and address of hospital _____ _____ Confined from _____ through _____		

GC-1430 (7-96) AIFS

<b>6. Cardiac</b> (if applicable)	(a) Functional capacity limitation (American Heart Ass'n): <input type="checkbox"/> Class 1 (none) <input type="checkbox"/> Class 2 (slight) <input type="checkbox"/> Class 3 (marked) <input type="checkbox"/> Class 4 (complete)						
	(b) Blood Pressure (last visit): _____ / _____ Systolic / Diastolic						
<b>7. Limitations</b>	(a) What are patient's present capabilities? _____ (b) What are present limitations (physical and/or mental)? _____ (c) What restrictions are placed on patient? _____						
<b>8. Physical Impairment</b> As defined in Federal Dictionary of Occupational Titles.	<input type="checkbox"/> Class 1 - No limitation of functional capacity; capable of heavy work*. No restrictions. (0-10%) <input type="checkbox"/> Class 2 - Medium manual activity.* (15-30%) <input type="checkbox"/> Class 3 - Slight limitation of functional capacity; capable of light work.* (35-55%) <input type="checkbox"/> Class 4 - Moderate limitation of functional capacity; capable of clerical/administrative (sedentary*) activity. (60-70%) <input type="checkbox"/> Class 5 - Severe limitation of functional capacity; incapable of minimal (sedentary*) activity. (75-100%) <input type="checkbox"/> Remarks: _____						
<b>9. Mental/Nervous Impairment</b> (if applicable)	Please define "stress" as it applies to this claimant. _____ Do you believe the patient is competent to endorse checks and direct the use of proceeds thereof? <input type="checkbox"/> No <input type="checkbox"/> Yes						
<b>10. Prognosis</b>	(a) What is the patient's prognosis? <input type="checkbox"/> Guarded <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Other (b) When do you feel patient's maximum medical improvement will be reached? <input type="checkbox"/> 1 Mo. <input type="checkbox"/> 1-3 Mos. <input type="checkbox"/> 3-6 Mos. <input type="checkbox"/> 6-9 Mos. <input type="checkbox"/> 1 yr. or longer (c) What is the estimated date of the patient's return to work? <input type="checkbox"/> own job/occ <input type="checkbox"/> other occ <input type="checkbox"/> no return expected (d) Do you consider the patient to be a viable candidate for Vocational Rehabilitation (job retraining)? <input type="checkbox"/> Yes <input type="checkbox"/> No, please explain _____						
<b>Remarks</b>	_____ _____ _____						
	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%;">Attending Physician's Name (Print)</td> <td style="width: 20%;">Specialty</td> <td style="width: 20%;">Degree</td> </tr> <tr> <td colspan="2">Address (Number, Street, City, State, Zip Code)</td> <td>Telephone (Include Area Code)</td> </tr> </table>	Attending Physician's Name (Print)	Specialty	Degree	Address (Number, Street, City, State, Zip Code)		Telephone (Include Area Code)
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