Mutual of Omaha Insurance Company
United of Omaha Life Insurance Company
Group Insurance Claims Management

3300 Mutual of Omaha Plaza
Omaha, NE 68175-0001
Toll Free (800) 877-5176
Fax (402) 997-1865
Email newdisabilityclaim@mutualofomaha.com

A Guide for Successfully Completing the Group Short-Term Disability Claim Form

Mutual of Omaha appreciates the opportunity to provide you with valuable income protection. We rely on the information you provide on this form to effectively determine if you qualify for group short-term disability benefits.

This guide provides information and instruction to help you successfully complete and submit the claim form. Please consult your employer/benefits administrator if you need assistance in providing information for the form.

Important Tips for Paper Copy Submission

- Prior to submission, make sure you have provided all required information and answered all questions completely and accurately. If information is missing or cannot be read, the processing of your form will be delayed.
- The following guidelines provide valuable information to help you successfully complete the form.
- Please make a copy of the completed form for your records before submitting it to Mutual of Omaha/United of Omaha.

Required Fraud Warnings

Before completing the claim form, please read the Required Fraud Warnings listed on the following page.

Guidelines for Section 1: Employee Statement

This section is to be completed by the Employee. Dates should include the month, date and year. In order to be considered complete, the form must be signed by you.

- Group ID Number for your Employer will consist of eight characters, beginning with "G000" and followed by four additional letters or numbers specific to your Employer.
- Job Title is the title of your position held with the Employer.
- The Hours Worked per Week is the number of hours you worked per week for the Employer.
- Height should be provided in feet and inches.
- Weight should be provided in pounds.
- Dominant Hand indicates whether you are primarily right- or left-handed.
- Date of Disability is the first day you were absent from work because of the disabling condition.
- Date First Treated is the date you first sought medical care because of the disabling condition.
- Other Income means money you are currently receiving or have applied to receive from any source in addition to your claim for disability benefits with Mutual of Omaha/United of Omaha.
- Medical records from your providers may be needed in order to make a determination on your claim. A completed authorization form will be needed to obtain them. To avoid any additional delays in the claim, please be sure to complete and submit the authorization forms with your claim application.

Authorization to Disclose Personal Information & Authorization to Disclose Health Information to My Employer

Both authorizations are to be completed by the Employee. Dates should include the month, date and year. In order to be considered complete, the form must be signed by you or your legal representative.

- By signing the authorization, you are applying for short-term disability benefits with Mutual of Omaha/United of Omaha and are agreeing to allow disclosure of personal information to the necessary parties for the purpose of claim processing.
- If the name associated with any of your medical records differs from the name provided on the form, provide any alternate names. This might occur in the event of a name change due to marriage or adoption.

Guidelines for Section 2: Employer's Statement

This section is to be completed by the Employer. Dates should include the month, date and year. In order to be considered complete, the form must be signed by the Employer.

- Group ID Number consists of eight characters, beginning with "G000" and followed by four additional letters or numbers.
- Date Covered Under This Plan indicates the date in which the Employee's coverage became effective.
- Please include copy of Employee's enrollment form, if applicable.

Guidelines for Section 3: Attending Physician's Statement

This section is to be completed by the Attending Physician. Dates should include the month, date and year. In order to be considered complete, the form must be signed by the Attending Physician.

Fraud Warnings

The following fraud language is attached to, and made part of this claim form. Please read and do not remove these pages from this claim form.

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Alaska: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arizona: For your protection Arizona law requires the following statement 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.

Arkansas and 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.

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.

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 or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

Delaware: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an 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: 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.

Idaho: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete, or misleading information is guilty of a felony.

Indiana: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files 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.

Maine: 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 or a denial of insurance benefits.

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.

Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment of insurance fraud, as provided in RSA 638:20.

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

New Mexico: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

Ohio: Any person who, with 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 is guilty of insurance fraud.

Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

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 such person to criminal and civil penalties.

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 with the penalty of 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.

Rhode Island: 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.

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 include imprisonment, fines and denial of insurance benefits.

Texas: 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.

If you live in a state other than mentioned above, the following statement applies to you: Any person who knowingly, and with intent to injure, defraud or deceive any insurer or insurance company, files a statement of claim containing any materially false, incomplete, or misleading information or conceals any fact material thereto, may be guilty of a fraudulent act, may be prosecuted under state law and may be subject to civil and criminal penalties. In addition, any insurer or insurance company may deny benefits if false information is related to a claim by the claimant.

Short-Term Disability Claim Form

Section 1 – Employee Statement (Answer all questions to avoid delay)

Current Employer's Name: Saint Mary's College of California | Group ID Number: G000BNN5 | Job Title | Hours Worked per Week

Employee Name

Employee Address | Employee City | Employee State | Employee ZIP

Employee (Area Code) Home Telephone Number | Employee (Area Code) Cellular Telephone Number | Employee Social Security Number

Employee Email Address

Employee Date of Birth | Height | Weight | Dominant Hand: ❑ Right ❑ Left | ❑ Male ❑ Female | ❑ Single ❑ Married ❑ Widowed ❑ Divorced

First date you were first unable to work? | Date First Treated | Estimated Return to Work Date

Nature of illness and when symptoms first appeared, or describe how and where accident occurred.

Was the disability work related? ❑ Yes ❑ No | Have you filed a workers' compensation claim? ❑ Yes ❑ No

Was disability related to a motor vehicle accident or is another third party liable? ❑ Yes ❑ No

Physician's Name | Physician's Specialty | Telephone ( ) | Fax ( )

Physician's Address | Date(s) you were seen by this physician From _____ To _____

Physician's Name | Physician's Specialty | Telephone ( ) | Fax ( )

Physician's Address | Date(s) you were seen by this physician From _____ To _____

Physician's Name | Physician's Specialty | Telephone ( ) | Fax ( )

Physician's Address | Date(s) you were seen by this physician From _____ To _____

Name of Hospital | Department of Treatment | Telephone ( ) | Fax ( )

Hospital's Address | Date(s) you were treated at the hospital From _____ To _____

Source of Income (Check all benefits you are receiving or are eligible to receive.)

❑ Social Security Retirement ❑ State Disability ❑ Unemployment ❑ State Paid Family or Paid Medical Leave
❑ Social Security Disability ❑ Pension Retirement ❑ No-Fault Insurance
❑ Canadian Pension Plan ❑ Pension Disability ❑ Other (include Individual or Group benefits)
❑ Workers' Compensation ❑ Short-Term Disability _____

*Medical records from your providers may be needed in order to make a determination on your claim. A completed Authorization form will be needed to obtain them. To avoid any additional delays in the claim, please be sure to complete and submit the Authorization forms with your claim application.

Information For Tax Withholding

If your request for benefits is approved, should Mutual of Omaha/United of Omaha withhold income taxes from your benefit checks? ❑ Yes ❑ No

If **Yes**, how much should be withheld from each check (the minimum is **$20.31** per week). $_____.00

Overpayment Notice: Should you become overpaid at any time during the duration of this claim we, Mutual of Omaha Insurance Company (Mutual) or United of Omaha Life Insurance Company (United), will request reimbursement of the overpaid amount. This amount is equal to the net benefit you received and any Federal Income Tax paid on your behalf for any time prior to current tax year. Your signature on the claim form authorizes Mutual or United to recover any overpaid Medicare and/or Social Security Tax that was paid on your behalf and certifies you will not attempt to recover a refund or credit of the Medicare and/or Social Security Tax with any Form W-2C that is furnished to you based on recoveries received.

Signature (Required for all claims.)

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.

The above statements are true and complete to the best of my knowledge and belief.

X_____ _____

Signature of Employee | Date

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Authorization to Release Personal Information

1. I (the undersigned) authorize any physician, medical or dental practitioner, pharmacist, other health care provider, hospital, clinic, or medical facility, insurer, reinsurer, insurance services support organization, employer, government agency, consumer reporting agency, or insurance policy or benefit plan administrator to release records containing the Personal Information of:

   Name of Claimant _____
   (Last) (First) (Middle)

   Date of Birth_____/_____/_____ Social Security Number_____-_____-_____

2. **Personal Information to be released:**
   - data or records regarding my medical history, treatment, prescriptions, consultations (including medical and psychological reports, records, charts, notes (excluding psychotherapy notes), X-rays, films or correspondence, and any medical condition I may now have or have had;
   - any information regarding insurance or benefit plan coverage, claims or benefits; and/or
   - any information, data or records regarding my activities (including records relating to my Social Security, Workers' Compensation, retirement income, financial information, earnings and employment history)

3. **You may release my Personal Information to:**
   Group Disability Management Services
   Mutual of Omaha Insurance Company/United of Omaha Life Insurance Company
   3300 Mutual of Omaha Plaza
   Omaha, NE 68175-0001
   or Fax: 402-997-1865 or Email: newdisabilityclaim@mutualofomaha.com

4. **I understand my Personal Information will be used by Mutual to evaluate my claim for benefits, or as required or permitted by law, and that if I refuse to sign this Authorization, my claim for benefits may not be paid. I also authorize Mutual to release my Personal Information as follows:**
   - to its reinsurer, or other persons or organizations performing business, legal or insurance support services in connection with my claim(s); or
   - to a vendor specializing in the application for Social Security Disability Benefits; or
   - to vendors/consultants providing me with wellness, disability or leave related services as part of an employer sponsored benefit plan; or
   - for self-insured disability plans only, to my employer; or
   - for fully insured plans to my employer for use in discussions with Mutual regarding my functional capacity, and any related restrictions and limitations, in order to facilitate my return to work; or
   - as otherwise required or permitted by law or as I further authorize

5. I understand my Personal Information may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

6. I understand that I may revoke this Authorization at any time by providing a written request to Mutual at the address above. If I revoke this Authorization, it will not affect any use or disclosure of Personal Information that occurred prior to Mutual's receipt of my revocation. If written revocation is not received, this Authorization will remain valid until 24 months after the date signed.

7. I understand that I am entitled to receive a copy of this Authorization and that a copy is as valid as the original.

RETAIN A SIGNED COPY FOR YOUR RECORDS

Name(s) used for records (if different than the name below): _____

_____

_____ _____
Signature of Claimant Date

If Applicable: I am the legal representative of the Claimant and I am authorized to grant permission on behalf of the Claimant.

Printed Name of Legal Representative_____

Signature of Legal Representative_____

Type of Legal Representative _____

THIS AUTHORIZATION COMPLIES WITH HIPAA AND OTHER FEDERAL AND STATE LAWS

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Authorization to Disclose Health Information to My Employer

I authorize Mutual of Omaha Insurance Company and United of Omaha Life Insurance Company to disclose health information about me to my employer, and to my employer's broker. I understand that this information will be used by my employer, and its broker, to monitor and manage the disability benefits program provided under my Group disability policy. I also understand that my employer and its broker will use the information solely for the purposes of auditing disability benefits paid, providing claims assistance, determining waiver or discontinuance of premium deductions, and coordinating with other subsidized salary continuance plans my employer may offer.

The health information which may be disclosed pursuant to this authorization includes such items as medical history, mental and physical condition, prescription drug records and alcohol or drug use.

I understand that I may refuse to sign this authorization. I realize that if I refuse to sign, my claim for benefits may not be paid.

This authorization will remain in effect for 24 contiguous months from the date I sign it. I understand that I may revoke this authorization at any time. If I would like to revoke this authorization, I should send my revocation request to:

ATTN: Group Disability Management Services
Mutual of Omaha Insurance Company/United of Omaha Life Insurance Company
3300 Mutual of Omaha Plaza
Omaha, NE 68175-0001

Or
Fax 402-997-1865

Or
Email newdisabilityclaim@mutualofomaha.com

I also understand that any revocation of this authorization will not affect any use or disclosure of health information that occurred prior to receipt of my revocation.

I understand that I am entitled to receive a copy of this authorization. A copy of this authorization is as effective as the original.

_____

(Printed Name and Address)

_____ _____

Signature Date

Or

If Applicable: I am the legal representative of the person whose financial and health information is to be disclosed, but I am authorized to grant permission on behalf of that person.

Printed Name of Legal Representative _____

Signature of Legal Representative _____

Type of Legal Representative _____

Date _____

RETAIN A SIGNED COPY FOR YOUR RECORDS

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Electronic Funds Transfer (EFT) Authorization

Direct Deposit of Disability Benefit Payments

I understand that by completing this form, I am authorizing United of Omaha Life Insurance Company to directly deposit into my bank account via Electronic Funds Transfer (EFT) payment(s) due to me under a contract issued by United of Omaha to my financial institution with the information provided below, for credit to my account. Furthermore, I authorize and direct the bank to charge said account or the account of my estate for any payment made in error as determined by United of Omaha and to refund any such payment made subsequent to my death or made in error and to refund any such payment to United of Omaha upon its written request to the bank.

I further understand and agree that it is my responsibility to ensure that all bank information reported on this form is accurate and correct for the appropriate deposit of my payment(s) and that United of Omaha can rely on this information and will have no obligation to ensure the correctness of the information. Completion of this form is not a guarantee that benefits will be paid.

I further understand and agree that any payment(s) made into an incorrect bank account pursuant to the information reported on this form, will be forfeited by me and that United of Omaha has no obligation to retrieve those funds or make replacement payment(s) to me.

I further understand and agree for myself, my heirs, executors and estate to indemnify and hold United of Omaha harmless from any and all loss or damage of any nature whatsoever, including costs or attorney's fees incurred by reason of said bank acting pursuant to this Authorization.

I further understand and agree that United of Omaha is not responsible for any bank charges or other costs associated with or arising out of this agreement.

I further understand that if my bank is not able to accept EFTs, checks will be mailed to my residence.

I reserve the right to revoke and cancel this authorization. Such revocation and cancellation shall be effective within 5 business days following United of Omaha's receipt of the notice.

Payee Information	**Bank Information**
Full Name	Bank Name
Address	Address
Address	Address
City	City
State and ZIP Code	State and ZIP Code
Telephone Number ( )	Telephone Number ( )
Social Security Number	Account Number
Policy Number G000BNN5	Bank ABA Routing/Transit Number
Claim Number	❑ Checking ❑ Savings *(Check only one)*
Payee Number *(for office use only)*	**Approved By/Date *(for office use only)***

X _____ _____

Payee Signature Date

Contact Information

Please attach EITHER **a voided check for checking** OR **a deposit slip for savings** and return with this form to:

United of Omaha Life Insurance Company
HO8W-GDMS
3316 Farnam Street
Omaha, NE 68172-7420

Should you have any questions regarding EFT, please feel free to contact our customer service representatives toll free at **800-877-5176** (Monday-Thursday between the hours of 7 a.m. and 5:30 p.m. and Friday between 7 a.m. and 5 p.m. CST).

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Section 2 – Employer's Statement (Answer all questions to avoid delay)

Company Name: Saint Mary's College of California

Group ID Number: G000BNN5

Class No. or Description

Division/Location No. or Description

Address | City | State | ZIP

Email Address

Employee's Name | Employee's Phone Number

Employee Address | Employee City | Employee State | Employee ZIP

Gross Weekly Earnings _____
(Please note: Benefits will be calculated based on premium received.)

Employee Date of Birth | Employee Social Security Number

Salary Effective Date _____ Number of weekly hours worked _____ Was disability caused by employment? ❑ Yes ❑ No

The employee is eligible for: ❑ Long-Term Disability ❑ State Disability ❑ Paid Family Leave ❑ Paid Medical Leave ❑ Group Life

Does the Employee contribute toward the premium? ❑ Yes ❑ No

If yes, what percent is paid by the Employee? _____% Is it Pre-tax or Post-tax? _____ Gross up _____

Employee's payroll classification: ❑ Exempt ❑ Non-Exempt ❑ Salaried ❑ Hourly ❑ Union ❑ Non-Union ❑ Other

How was the Employee paid? _____

Is the Employee continuing to receive compensation or pay since their last day of work? ❑ Yes ❑ No

Is Employee eligible for Vacation/PTO? ❑ Yes ❑ No If Yes, please answer the following questions.

Weekly amount?_____ Date benefits begin?_____ Date benefits end?_____

Is Employee eligible for Salary Continuation? ❑ Yes ❑ No If Yes, please answer the following questions.

Weekly amount?_____ Date benefits begin?_____ Date benefits end?_____

Is Employee eligible for Sick Leave? ❑ Yes ❑ No If Yes, please answer the following questions.

Weekly amount?_____ Date benefits begin?_____ Date benefits end?_____

Is Employee eligible for: ❑ Paid Family Leave ❑ Paid Medical Leave State_____

Weekly amount?_____ Date benefits begin?_____ Date benefits end?_____

Date of Hire_____ Date Covered Under This Plan_____

Has workers' compensation claim been filed? ❑ Yes ❑ No

Did the claimant have prior STD coverage with another carrier while employed with you? ❑ Yes ❑ No

If Yes, date the coverage was effective and name of prior carrier. Effective date_____ Name_____

Important Notice: For Employees age 60 or over, refer to the policy provisions regarding group life continuation and conversion rights.

If the employee is no longer working the minimum hours required under the policy, indicate why:
❑ Termination ❑ Layoff ❑ Personal Leave of Absence ❑ Medical Leave of Absence (e.g., FMLA) ❑ Other (explain)_____

Please contact Employee's direct supervisor and then check the strength demand below which best describes the Employee's job:

Check One		
❑	S – Sedentary	10 lbs. Maximum lifting, occasional lift/carry of small articles. Some occasional walking or standing may be required.
❑	L – Light	20 lbs. Maximum lifting with frequent lift/carry up to 10 lbs. A job is light if less lifting is involved but significant walking/standing is done or if done mostly sitting but requires push/pull on arm or leg controls.
❑	M – Medium	50 lbs. Maximum lifting with frequent lift/carry up to 25 lbs.
❑	H – Heavy	100 lbs. Maximum lifting with frequent lift/carry up to 50 lbs.
❑	V – Very Heavy	Over 100 lbs. Lifting with frequent lift/carry over 50 lbs.

Employee's Job Title (Attach job description) | Last Day at Work | First Work Day Missed

Has the Employee returned to work? ❑ Yes ❑ No

a) If Yes, when?_____ b) If No, what is the estimated return to work date?_____

If the claimant is released by the doctor to return to work in either a part-time capacity, with temporary job modifications, or a combination of both, would your company be able to consider these accommodations to help facilitate return-to-work? ❑ Yes ❑ No

Print Name | Signature of Person Completing Claim Form | Title of Person Completing Claim Form

Date Signed | (Area Code) Phone Number | (Area Code) Fax Number | Email Address

Please notify us if the Employee returns to work after the submission of this form.

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Section 3 – Attending Physician's Statement (Answer all questions to avoid delay)

3300 Mutual of Omaha Plaza, Omaha, NE 68175-0001 | Fax: (402) 997-1865

Employer Name: Saint Mary's College of California

Group ID Number: G000BNN5

Name of Patient (Last, First, MI) – Please Print | Date of Birth | Employee's Phone Number

Employee Address | Employee City | Employee State | Employee ZIP

Diagnoses | ICD-10 Code(s)

Symptoms | Date symptom first appeared

Initial date of treatment | Last date of treatment | Next date of treatment/office visit

Is disability due to: ❑ Accident/Injury ❑ Sickness | Is the disability work related? ❑ Yes ❑ No

If applicable, list the surgical code(s)/procedure(s) – Describe fully and provide dates, if any.

If disability is due to Pregnancy, please provide the information below:

Date of Last Monthly Period | Expected Date of Delivery | Expected Type of Delivery: ❑ Vaginal ❑ Cesarean Section

Actual Date of Delivery | Actual Type of Delivery: ❑ Vaginal ❑ Cesarean Section

If any of the following questions are answered "Yes," then please provide the information to the right of that question.

Was the patient treated in an Emergency Room? ❑ Yes ❑ No | Date treated | Name of Hospital | Name of Physician

Did another physician treat or will be treating the patient? ❑ Yes ❑ No | Date treated | Physician's Name and Address

Was the patient hospital confined? ❑ Yes ❑ No | Date Confined In Hospital: From_____ To_____ | Name of Hospital

Did patient have outpatient surgery in a hospital or ambulatory surgical center? ❑ Yes ❑ No | Date of Surgery | Name of Facility

Functional Limitations – Abilities

Indicate frequency per day the listed activity can be performed.

(n = never, o = occasional, f = frequent, c = constant)

Lifting

_____ 1-5 lbs.
_____ 6-10 lbs.
_____ 11-25 lbs.
_____ 26-50 lbs.
_____ 51-100 lbs.
_____ Over 100 lbs.

Carrying

_____ 1-5 lbs.
_____ 6-10 lbs.
_____ 11-25 lbs.
_____ 26-50 lbs.
_____ 51-100 lbs.
_____ Over 100 lbs.

Indicate longest single time duration each activity can be performed.

_____ Sitting
_____ Total time on feet
_____ Standing
_____ Walking
_____ Bending
_____ Squatting
_____ Stooping

_____ Kneeling
_____ Inside
_____ Outside
_____ Working with Others
_____ Other (explain)_____

_____ R: Finger Dexterity
_____ L: Finger Dexterity
_____ R: Below Shoulder
_____ L: Below Shoulder
_____ R: Above Shoulders
_____ L: Above Shoulders

Reaching

Please notify us if the Employee returns to work after the submission of this form.

Mental Limitations – Abilities

Please check off the appropriate response of the person's ability to adapt to these specific job situations at this time.

	Unlimited	Somewhat Limited	Markedly Limited	Unable to Perform
Follow work rules	❑	❑	❑	❑
Perform repetitive, or short cycle work	❑	❑	❑	❑
Perform at a constant pace	❑	❑	❑	❑
Maintain attention and concentration	❑	❑	❑	❑
Perform a variety of duties	❑	❑	❑	❑
Understand, remember and carry out complex job instructions	❑	❑	❑	❑
Attain set limits and standards	❑	❑	❑	❑
Relate to coworkers	❑	❑	❑	❑
Interact with supervisors	❑	❑	❑	❑
Interact with the public/customers	❑	❑	❑	❑
Use judgment and make decisions	❑	❑	❑	❑
Direct, control or plan activities of others	❑	❑	❑	❑
Influence people in their opinions, attitudes and judgments	❑	❑	❑	❑
Expressing personal feelings	❑	❑	❑	❑
Work alone or apart in physical isolation from others	❑	❑	❑	❑

What functions of the person's own/usual occupation is the person unable to perform? (Please provide rationale here, if not already provided.)

What functional restrictions have been placed on this person?

When do you expect the patient to return to prior leveling functioning? _____

Would you recommend vocational rehabilitation for this patient? ❑ Yes ❑ No

The patient has been continuously disabled (unable to work) from _____ to _____.

The patient should be able to work: ❑ Full-time ❑ Part-time on _____ or a specific date is unavailable, in:
❑ 1 month ❑ 1-3 months ❑ 3-6 months ❑ Other (please specify)

What is your treatment plan for the patient's return to work or return to prior level function?

Name of the Attending Physician – Please Print | Specialty/Degree(s) | Tax Identification Number

Address (No., Street, City, State ZIP) | (Area Code) Telephone Number | (Area Code) Fax Number

If necessary, whom can we contact at the attending physician's office for additional information?

Name | (Area Code) Telephone Number

Signature of Attending Physician | Date

Please notify us if the Employee returns to work after the submission of this form.