

SECTION 2 (TO BE COMPLETED BY ATTENDING PHYSICIAN)

ALL QUESTIONS MUST BE ANSWERED

Required: ATTACH CURRENT MEDICAL RECORDS – REQUEST WILL NOT BE PROCESSED WITHOUT MEDICAL RECORDS.

Please note: Any fees for the completion of this form or copies of medical records are solely the responsibility of the member.

Patient's (Dependent's) Name:

1. Nature and cause of disability. (Provide complete diagnosis. You may attach a narrative summary relative to diagnosis/prognosis.)

2. Is the patient incapable of self-sustaining employment due to this physical or mental disability? Yes No

3. Will the patient be capable of employment in the future?

Yes No Questionable If **yes**, supply:

Type of work dependent will be capable of performing:

Number of work hours per week:

Approximate date returning to work:

4. How does this condition(s) restrict/limit the patient's ability to engage in normal activities?

5. Has this disability been diagnosed as permanent? Yes No If **no**, how long will this condition last?

6. Is the patient currently incapable of self-support because of disability? Yes No

7. Estimate when patient will be capable of self-support: Approximate Date: Never

8. Date/age of onset of disability:

9. Date of patient's last examination:

10. Disability has been continuous since (date):

11. Treatment frequency: Date of first visit: Frequency: Weekly Monthly Quarterly Other _____

Attending Physician's Name:

Address (city, state, zip):

Phone Number:

Additional Comments:

***** PLEASE INCLUDE COPIES OF CURRENT MEDICAL RECORDS *****

Physician's Signature:

Date Signed: