ATTENDING PHYSICIAN'S STATEMENT – PROGRESS REPORT

(The patient is responsible for the completion of this form without expense to the Company. Please fully answer each question. Attach additional sheets if necessary.)

GROUP _____ PATIENT'S SOCIAL SECURITY NO OR ID _____

1. PATIENT'S NAME: _____ DATE OF BIRTH: _____/_____/_____/_____
   (First) (Middle) (Last) *MM DD YYYY*

2. CURRENT MEDICAL CONDITION(s):

   PRIMARY DIAGNOSIS: _____ ICD-9 CM CODE: _____

   SECONDARY DIAGNOSIS:_____ ICD-9 CM CODE: _____

3. DATES YOU HAVE PROVIDED TREATMENT TO THE PATIENT SINCE YOUR LAST REPORT TO US:
   _____

4. CURRENT OBJECTIVE FINDINGS ***(Include x-rays, lab results and clinical findings. If pregnancy, also give LMP and EDC)***:
   _____

5. HAS PATIENT BEEN HOSPITALIZED SINCE THE DATE OF YOUR LAST REPORT TO US? YES ☐ NO ☐ ***(If "YES", provide reason, hospital name and address and dates of confinement):***
   _____

6. NATURE OF TREATMENT CURRENTLY BEING PROVIDED OR PLANNED: ***(Include surgery and medications prescribed if applicable:***
   _____

7. HAVE YOU REFERRED THE PATIENT TO ANOTHER PRACTITIONER? YES☐ NO☐ ***(If "Yes", please provide the name and address of all applicable physicians or practitioners)***: _____
   _____

8. IN YOUR OPINION IS THE PATIENT ABLE TO WORK AT THIS TIME? YES☐ NO☐
   IF "NO", WHEN DO YOU EXPECT THAT THE PATIENT WILL BE ABLE TO PERFORM SOME WORK? ___/___/_____

9. IS THERE ANY TYPE OF JOB MODIFICATION OR ACCOMODATION THAT WOULD ENABLE THE PATIENT TO WORK AT THIS TIME?
   YES☐ NO☐ ***(If "Yes", please describe)***_____
   _____

10. BASED ON YOUR OBJECTIVE FINDINGS AND YOUR MEDICAL OPINION:

    a) THE PATIENT WAS UNABLE TO WORK FROM: _____/_____/_____ TO: _____/_____/_____
    (Mo.) (Day) (Year) (Mo.) (Day) (Year)

    b) THE PATIENT WAS ABLE TO PERFORM SOME WORK FROM: _____/_____/_____ TO: _____/_____/_____
    (Mo.) (Day) (Year) (Mo.) (Day) (Year)

11. LIST ALL CURRENT RESTRICTIONS AND LIMITATIONS YOU HAVE PLACED ON THE PATIENT'S WORK AND PERSONAL ACTIVIITES DUE TO HIS OR HER MEDICAL CONDITION ***(If none, indicate" NONE):***
    _____
    _____

12. HAS THE PATIENT BEEN RELEASED FROM YOUR CARE? YES☐ NO☐

    IF "YES" DATE RELEASED RELEASED FROM YOUR CARE: _____/_____/_____ (MO) (DAY) (YEAR)

    IF "NO", DATE OF NEXT SCHEDULED TREATMENT OR EVALUATION: _____/_____/_____ (MO) (DAY) (YEAR)

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTINAING 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 STATE VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

ATTENDING PHYSICIAN'S DECLARATION AND SIGNATURE

I declare that the answers on this statement are complete and true to the best of my knowledge and belief. I understand that periodic updates (including providing copies of medical records when requested) will be required in the event of a continuing claim.

_____ _____ ( ) _____
PROVIDER'S NAME/SPECIALTY (PLEASE PRINT) TAX ID/SOCIAL SECURITY # TELEPHONE NUMBER

_____ _____ _____
STREET ADDRESS CITY STATE ZIPCODE PROVIDER'S SIGNATURE DATE SIGNED

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