THE HARTFORD

Clear Form

HARTFORD LIFE INSURANCE COMPANY
HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

Please print

Name of Patient _____ Date of Birth Month Day Year

Patient's address _____
Street *City* *State or Province* *Zip Code or Postal Code*

Employer's name | Group Policy or Participation No. | Social Security No.

I hereby authorize release of information requested on this form by the below named physician for the purpose of claim processing.

Signed (Patient) ▶ Date _____

ATTENDING PHYSICIAN'S STATEMENT OF DISABILITY

The patient is responsible for the completion of this form without expense to the Company. Space is available on the reverse side if you wish to amplify your answers.

1. History

(a) When did symptoms first appear or accident happen? Mo._____ Day _____ Year _____

(b) On what day do you feel the insured was first unable to work? Mo._____ Day _____ Year _____

(c) Has patient ever had same or similar condition? ☐ Yes ☐ No If "Yes," state when and describe.

(d) Is condition due to injury or sickness arising out of patient's employment? ☐ Yes ☐ No ☐ Unknown

(e) Names and addresses of other treating physicians.

2. Diagnosis (including any complications)

(a) Date of last examination Mo._____ Day _____ Year_____

(b) Diagnosis (including any complications)

(c) Subjective symptoms

(d) Objective findings (including current X-rays, EKG's, Laboratory Data and any clinical findings).

(e) If disability is due to pregnancy, what is expected/was delivery date? Mo._____ Day _____ Year_____
Please describe any complications that would extend this disability longer than for a normal pregnancy.

3. Dates of Treatment

(a) Date of first visit Mo. _____ Day _____ Year _____

(b) Date of last visit Mo. _____ Day _____ Year _____

(c) Frequency Mo. _____ Day _____ Year _____
☐ Weekly ☐ Monthly ☐ Other (Specify)

4. Nature of Treatment (including surgery and medications prescribed, if any)

5. Progress

(a) Has patient ☐ Recovered? ☐ Improved? ☐ Unchanged? ☐ Retrogressed?

(b) Is patient ☐ Ambulatory? ☐ House confined? ☐ Bed confined? ☐ Hospital confined?

(c) Has patient been hospital confined? ☐ Yes ☐ No If "Yes," give name and address of hospital _____

_____ Confined from _____ through _____

6. Cardiac (if applicable)

(a) Functional Capacity (American Heart Association) ☐ Class 1 (No limitation) ☐ Class 2 (Slight limitation) ☐ Class 3 (Marked limitation) ☐ Class 4 (Complete limitation)

(b) Blood pressure *(last visit)* Systolic _____ /Diastolic _____

7. Physical Impairment (*as defined in Federal Dictionary of Occupational Titles)

- ☐ Class 1-No Limitation of functional capacity; capable of heavy work* — No restrictions (0- 10%)
- ☐ Class 2-Medium manual activity* — (15- 30%)
- ☐ Class 3-Slight limitation of functional capacity; capable of light work* — (35- 55%)
- ☐ Class 4-Moderate limitation of functional capacity; capable of clerical/administrative (sedentary*) activity — (60- 75%)
- ☐ Class 5-Severe limitation of functional capacity; incapable of minimal (sedentary*) activity — (75- 100%)
- ☐ Remarks:

8. Mental/Nervous Impairment (if applicable)

(a) Please define "stress" as it applies to this claimant

(b) What stress and problems in interpersonal relations has claimant had on job?

- ☐ Class 1-Patient is able to function under stress and engage in interpersonal relations (no limitations)
- ☐ Class 2-Patient is able to function in most stress situations and engage in only limited interpersonal relations (slight limitations)
- ☐ Class 3-Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations (moderate limitations)
- ☐ Class 4-Patient is unable to engage in stress situations or engage in interpersonal relations (marked limitations)
- ☐ Class 5-Patient has significant loss of psychological, physiological, personal and social adjustment (severe limitations)
- ☐ Remarks:

9. Do you believe the patient is competent to name or change a beneficiary on a life insurance policy? ☐ **Yes** ☐ **No**

10. Prognosis

	Patient's job	Any other job
(a) Is patient now totally disabled?	☐ Yes ☐ No	☐ Yes ☐ No
(b) If not totally disabled, what were the inclusive dates of disability?	Mo. Day Year	Mo. Day Year
(c) If not now totally disabled, when was the patient able to resume work?	☐ Full time ☐ Part time — Mo. Day Year	☐ Full time ☐ Part time — Mo. Day Year
(d) What duties of patient's job is he/she incapable of performing?		
Do you expect a fundamental or marked change in the future?		
(1) If "Yes," when will patient recover sufficiently to perform duties?	Mo. Day Year	☐ Yes ☐ No ☐ 1 mo. ☐ 3-6 mos. ☐ 1-3 mo. ☐ Never — Mo. Day Year
(2) If "No," please explain.		☐ Yes ☐ No ☐ 1 mo. ☐ 3-6 mo. ☐ 1-3 mo. ☐ Never

11. Rehabilitation

(a) Is patient a suitable candidate for further rehabilitation services? (i.e., cardiopulmonary program, speech therapy, etc.)
☐ Yes ☐ No

(b) Would job modification enable patient to work with impairment? ☐ Yes ☐ No
If "Yes," explain under remarks.

	Patient's job	Any other job
(c) When could trial employment commence?	☐ Full time ☐ Part time	☐ Full time ☐ Part time
	Mo. Day Year	Mo. Day Year
(d) Would vocational counseling and/or retraining be recommended?	☐ Yes ☐ No	

12. Remarks

Name (attending physician) *Please print.* | Degree/Specialty | Telephone

Street Address | State or Province | Zip Code or Postal Code

Signature | Date | Taxpayer Identifying Number