aetna℠

Attending Physician's Statement

Total Disability – Life Insurance

Patient Instructions: The Patient will complete **Section 1** and fill in their name at the top of Pages 2, 3 and 4.

The Patient must sign on the bottom of page 4.

The ***Patient*** is responsible for completing this section, and for **ensuring** that **their Attending Physician completes the remainder of this statement**. The Patient is responsible for paying any fees that may be charged for completion of this form by their physician.
If you have any questions, please call 1-800- 523-5065.

1. Patient Information

(a) _____ / _____ / ____ / ____ / ____ / _____
Patient Name (Last, First, Middle Initial) Social Security Number Birth Date (MM/DD/YYYY) Height-Weight(lb)

(b) Patient Gender ☐ Male ☐ Female

(c) Patient Home Address Required (Current No., St., Town, State, ZIP – no PO boxes) ☐ Check if New

_____

(d) Patient Telephone Number (____) _____ ☐ Check if New

(e) Mailing Address, if different from Home address

_____

(f) Patient Employer (Name/City/State)

_____

(g) Job Title Occupation _____

2. Physician Instructions - The Physician will complete Sections 2 through 7.

The ***Attending Physician*** should **complete the items below,** based upon a **recent examination.** Attach additional documentation as needed.

This is a time-sensitive document. A delay in returning a completed Attending Physician's Statement could result in your patient's disqualification from receiving valuable insurance benefits.

Your patient has applied for a benefit under the Total Disability provision of a group life insurance policy. Please provide us with the following information so that we can determine your patient's eligibility for the benefit. If you have any questions, please call **1-800-523-5065**.

Please complete form in its entirety and fax to 1-800-238-6239. Pages 2 and 3 MUST be completed before faxing.

3. Impairing Diagnosis & Treatment

(a) For medical reasons, the patient will need to be absent from work due to a disability beginning on _____ and ending on _____
(MM/DD/YYYY) (MM/DD/YYYY)

REQUIRED:

(b) Primary Diagnosis _____ Primary ICD Code _____

Secondary Diagnosis _____ Secondary ICD Code _____

Other Diagnoses _____ Other ICD Code _____

(c) Height _____ Weight _____ Date Measured (MM/DD/YYYY) _____

(d) Surgery Date _____

Primary Procedure _____ Primary CPT Code _____

Secondary Procedure _____ Secondary CPT Code _____

Other Procedures _____ Other CPT Codes _____

(e) Medication(s)/Dose/Frequency _____

_____

Impairment from medication effects _____

(f) Other Treating Physicians

Name _____ Specialty _____ City _____ State _____

Name _____ Specialty _____ City _____ State _____

Name _____ Specialty _____ City _____ State _____

Patient Name *(Last, First Middle Initial)* **Required**

4. History

(a) Symptoms and severity:

(b) Date symptoms first appeared or accident happened _____

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

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

(e) Is patient still under your care for this condition? ☐ No ☐ Yes, date service terminated _____ (MM/DD/YYYY)

(f) Treatment summary:

(g) Office visit dates: First _____ (MM/DD/YYYY) Last _____ (MM/DD/YYYY) Next _____ (MM/DD/YYYY) Frequency of appointments _____

(h) Was patient recently hospitalized? ☐ No ☐ Yes Date hospitalized: Admit _____ (MM/DD/YYYY) Discharge _____ (MM/DD/YYYY)

(i) Hospital Name/City/State

5. Current Status

(a) Patient has ..... ☐ Improved ☐ Stabilized ☐ Regressed ☐ Not Applicable

(b) Is there a medical contraindication for patient to participate in Vocational Rehabilitation (job training) programs?

☐ No ☐ Yes, please explain:

(c) In your opinion, is your patient motivated to return to work? ☐ No ☐ Yes

Patient Name *(Last, First Middle Initial)* **Required**

6. Abilities/Limitations

(a) **Patient is: Place remarks in item (e) below, if applicable.**

- Competent to endorse checks and direct the use of proceeds thereof ..... ☐ Yes ☐ No ☐ Other/describe in (e)
- Able to work with others ..... ☐ Yes ☐ No ☐ Other/describe in (e)
- Able to give supervision ..... ☐ Yes ☐ No ☐ Other/describe in (e)
- Able to work cooperatively with others in group setting ..... ☐ Yes ☐ No ☐ Other/describe in (e)
- Able to do? **Select one: Place remarks in item (e) below, if applicable.**

☐ **Heavy work** activity. No limitations of functional capacity.

☐ **Medium work** activity. Exerting 20-50 pounds of force occasionally, and/or 10-25 pounds of force frequently, and/or greater than negligible up to 10 pounds of force constantly

☐ **Light work** activity. Exerting up to 20 pounds of force occasionally and/or up to 10 pounds of force frequently

☐ **Sedentary work** activity – moderate limitation of functional capacity. Exerting up to 10 pounds of force occasionally. Sedentary work involves sitting most of the time, but may involve walking or standing for brief periods of time.

☐ **No ability to work.** Severe limitation of functional capacity; incapable of minimal activity

☐ **Other.** Place remarks in item (e) below.

(b) **What medical restrictions/limitations are you placing on patient?** ***(Activities of Daily Living, Driving, Lifting, Pulling, Pushing, and Amounts, etc.)***

- Number of Hours patient is capable of working in a day: ☐ 12 ☐ 10 ☐ 8 ☐ 6 ☐ 4 ☐ 2 ☐ 1 Hours/Day
- Number of Days per week patient is able to work: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 Days/Week
- Date you prescribed restriction on work activities Month _____ Day _____ Year _____
- How long are these restrictions/limitations in effect? _____ Days _____ Weeks _____ Months ☐ No Longer
- Estimated return to work date? _____ (MM/DD/YYYY) modified duty _____ (MM/DD/YYYY) full duty

(c) **Objective findings that substantiate impairment** *(current laboratory, physical and/or mental status examination, and other testing)*

(d) Subjective findings that substantiate impairment:

(e) Other/Comments:

7. Physician Information

Physician's Name (please print)	Degree	Specialty/Board Certification
Address	Telephone Number	Fax Number
	Taxpayer Identification Number	
Signature		Date

The Genetic Information Non-Discrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you **not** provide any genetic information when responding to this request for medical information. Genetic information as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Please mail or fax this completed questionnaire to:

Aetna Life Insurance Service Center
PO Box 14548
Lexington, KY 40512-4548
Fax Number: 1-800-238-6239

If you have any questions please call our Customer Service Unit at **1-800-523-5065.**

Patient Name *(Last, First Middle Initial)* **Required**

8. Misrepresentation Notice

Any person who knowingly and with intent to injure, defraud or deceive 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.

Attention Alabama Residents: 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.

Attention Arkansas, District of Columbia, Rhode Island and West Virginia Residents: 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.

Attention California Residents: For your protection, California law requires notice of 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.

Attention Colorado Residents: 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.

Attention Florida Residents: 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.

Attention Kansas and Missouri Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may have violated state law.

Attention Kentucky Residents: Any person who knowingly and with intent to defraud any insurance company or other person files a 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 may subject such person to criminal and civil penalties.

Attention Louisiana Residents: 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 is guilty of a crime and may be subject to fines and confinement in prison.

Attention Maine and Tennessee Residents: 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 denial of insurance benefits.

Attention Maryland Residents: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Attention New Jersey Residents: Any person who includes any false or misleading information on an application for an insurance policy or knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Attention New York Residents, the following statement applies only to your AD&D and Disability coverage: 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 shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

Attention North Carolina Residents: Any person who knowingly and with intent to injure, defraud or deceive 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 may be a crime and subjects such person to criminal and civil penalties.

Attention Ohio Residents: Any person who, with intent to defraud or knowing 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.

Attention Oklahoma Residents: 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.

Attention Oregon Residents: Any person who with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may have violated state law.

Attention Pennsylvania Residents: 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.

Attention Puerto Rico Residents: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

Attention Vermont Residents: Any person who knowingly and with intent to injure, defraud or deceive 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 may be a crime and may subject such person to criminal and civil penalties.

Attention Virginia Residents: Any person who knowingly and with intent to injure, defraud or deceive 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 act, which is a crime and subjects such person to criminal and civil penalties.

Attention Washington Residents: 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.

I affirm that the answers on this form are complete and true to the best of my knowledge and belief. I acknowledge that I have read the fraud notices listed above.

Employee Signature	Date