Prudential

The Prudential Insurance Company of America
Waiver of Premium Unit
P.O. Box 70183, Philadelphia, PA 19176
Tel 800-524-0542 Fax 877-862-0269

Attending Physician Statement

1. Claimant Information – To Be Completed By Claimant

First name | MI | Last name

Date of birth (mm/dd/yyyy) | Last 4 of Social Security Number | Claim Number | **Gender** ☐ Male ☐ Female

☐ **Please check if your life insurance policy is sponsored through your employer, and provide the information below:**

Employer's Name | Location/Division

Control Number(s):

☐ **Please check if you have an Individual Life Insurance policy that was not purchased through an employer, and provide your policy number(s):**

Policy Number(s)

2. Condition History/Prognosis – To Be Completed By Physician

1. Please indicate the dates you are certifying the patient's disability or loss of function based on the medical records reviewed.

   Total disability From / / To / /

2. If you were not treating the patient at the onset of disability and have records from the prior provider, please supply:

   Prior provider's name _____ Telephone number _____

   Period of time records cover: From / / To / /

3. Clinical Diagnosis **ICD Code is Required** Diagnosis

   Primary

   Secondary

   Tertiary

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2. Condition History/Prognosis – To Be Completed By Physician (continued)

4. Do you feel the claimant is competent to endorse checks and direct the use of proceeds? ☐ Yes ☐ No

5. What was the date of the patient's first office visit? (mm/dd/yyyy) ___/___/___
Most recent visit (mm/dd/yyyy) ___/___/___
Next scheduled visit (mm/dd/yyyy) ___/___/___

Frequency of visits ☐ Weekly ☐ Monthly ☐ Other Specify

6. Has the patient been medically cleared to return/seek employment? ☐ Yes ☐ No

If Yes, as of what date were they cleared? ___/___/___ **Specify:** ☐ Without restrictions ☐ With restrictions

If no, what is the expected duration the limitation/restrictions will be medically necessary?

7. Has the patient reached maximum medical improvement? ☐ Yes ☐ No

8. Have you addressed a return-to-work plan with the patient? ☐ Yes ☐ No

Please explain.

3. Clinical Workup

1. Please provide information regarding pertinent tests, therapies, procedures and surgeries:
Please attach any related diagnostic information to support to claim.

Tests/Therapies	Date	Results at Onset of Disability	Date	Current Results

Procedures/Surgeries	Date	Type of Procedure/Surgery	Outcome/Complication

2. Dominant hand ☐ Left ☐ Right Height Weight

3. List current medications including their dose and frequency.

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4. Physical Capacity

1. In your medical opinion please indicate the extent to which the patient's ability to perform the following activities in an 8-hour workday is limited by his or her condition. (Circle or check the number of hours).

The patient has the work capacity to:

Sit for: 0 1 2 3 4 5 6 7 8 hours at a time Stand for: 0 1 2 3 4 5 6 7 8 hours at a time

Walk for: 0 1 2 3 4 5 6 7 8 hours at a time Drive for: 0 1 2 3 4 5 6 7 8 hours at a time

Does the patient have capacity in terms of:

% of time	Never 0%	Occasionally 1-33%	Frequently 34-66%	Constantly 67-100%
Climbing Stairs	☐	☐	☐	☐
Climbing Ladders	☐	☐	☐	☐
Balancing/Heights	☐	☐	☐	☐
Stooping	☐	☐	☐	☐
Kneeling/Crawling	☐	☐	☐	☐
Reaching Desk Level	☐	☐	☐	☐
Reaching Overhead	☐	☐	☐	☐
Right Handling/Fingering	☐	☐	☐	☐
Left Handling/Fingering	☐	☐	☐	☐
Lifting/Carrying (up to 10 pounds)	☐	☐	☐	☐
Lifting/Carrying (up to 20 pounds)	☐	☐	☐	☐
Lifting/Carrying (up to 50 pounds)	☐	☐	☐	☐

Please list any additional Limitations and Restrictions:

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4. Physical Capacity (Continued)

2. Visual impairment (if applicable)

Date	Test	OD	OS
	Visual Field Percentage		
	Visual Acuity - Corrected		
	Visual Acuity - Not Corrected		

5. Other Treating Physicians/Hospitalization

First Name	Last Name	Speciality	Phone Number

Hospital Name	Date of Admission	Date of Release	Phone Number

Remarks:

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6. Behavioral Health

(Please complete this section if the disabling condition is due to a behavioral health disorder)

1. When was the patient first diagnosed with the behavioral health disorder?
2. Do you provide medications management? ☐ Yes ☐ No
   If Yes, indicate if the patient adheres to treatment recommendations and provide the treatment response
3. Do you provide counseling/therapy? ☐ Yes ☐ No
   If Yes, indicate if the patient adheres to treatment recommendations and provide the treatment response
4. Has formal psychological testing been completed? ☐ Yes ☐ No **If Yes, please provide the following:**

Type of testing | ***Date*** (mm/dd/yyyy)

Name of testing provider (Provide a copy of report, if available)

5. Is there a history of alcohol or substance abuse? **If Yes, the patient (please check one):**

☐ ***is actively using*** ☐ ***has been in remission for*** _____ ***months*** _____ ***years***

7. Fraud Notice

Physician's first name | MI | Physician's Last name

Street address | Apt/Suite (optional)

City | State | ZIP Code

Specialty | Telephone number | Fax number

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person, or knowing that he is facilitating commission of a fraud, submits incomplete, false, fraudulent, deceptive or misleading facts or information when filing an insurance application or a statement of claim for payment of a loss or benefit commits a fraudulent insurance act, is/may be guilty of a crime and may be prosecuted and punished under state law. Penalties include fines, civil damages and criminal penalties, including confinement in prison. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant or if the applicant conceals, for the purpose of misleading, information concerning any fact material thereto.

I have read and understand the terms and requirements of the fraud warning as I certify the above statements are true.

X
Physician signature

month / day / year

Return this page with the completed form.