

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 Claim Number
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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First name		MI Last n	ame			Claim Number		
2. Conditio	n History/	/Prognosis – To Bo	e Comp	leted By P	hysiciar	ı (continued)		
4. Do you feel the	claimant is cor	mpetent to endorse checks	and direct	the use of proce	eds? Ye	s No		
	/ date of the patite? (mm/dd/yyyy		/	dd/yyyy)	Next schedu	/		
Frequency of v	visits Week	ly Monthly Other S	pecify					
6. Has the patient If Yes, as of what of		y cleared to return/seek em	ployment?	I .	thout restric	tions With restrictions		
If no, what is t	the expected d	uration the limitation/restric	tions will	be medically ned	essary?			
•	ssed a return-to	mum medical improvement: o-work plan with the patient		No No				
3. Clinical	Workup							
· ·	_	arding pertinent tests, thera nostic information to suppor	-	_	eries:			
Tests/Therapies	s/Therapies Date Results at Onset of		Disability Date		Current Re	rent Results		
Procedures/Surge	ries C	Date Type		Procedure/Surg	ery Out	Outcome/Complication		
2. Dominant hand	Left F	Right Height	Weig	ht				
3. List current med	dications includ	ding their dose and frequen	су.					



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4. Physical Capacity													
In your medical opinion place 8-hour workday is limited.									the	follo	owin	ig ad	ctivities in an
The patient has the work cap	acity to:												
Sit for: 0 1 2 3 4 5	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								hours at a time				
Walk for: 0 1 2 3 4 Does the patient have capacit		at a time	Drive for:	0	1	2	3	4	5	6	7	8	hours at a time
% 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 Lim	itations and Restrictions	S:											
													I

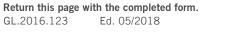




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st name	MI La	st name		Cla	nim Number	
	apacity (Continued)	or name		O la	iiii itailisei	
-						
Visual impairment (i			OD			
ate	Test	Test				
	Visual Field Percentage					
	Visual Acuity - Corrected	Visual Acuity - Corrected				
	Visual Acuity - Not Correcte	ed				
5. Other Treat	ting Physicians/Hospit	alization				
irst Name	Last Name	Speciality		Phone Number		
		'				
lospital Name	Date of Admission	Date of Release	Date of Release		mber	
emarks:						



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6. Behavioral Health (Please complete this section if the disabling condition is due to a	behavioral health disorder)
 When was the patient first diagnosed with the behavioral health d Do you provide medications management? Yes No If Yes, indicate if the patient adheres to treatment recommendation 	
Do you provide counseling/therapy? Yes No If Yes, indicate if the patient adheres to treatment recommendation	ons and provide the treatment response
4. Has formal psychological testing been completed? Yes N	lo If Yes, please provide the following:
Type of testing	<i>Date</i> (mm/dd/yyyy)
5. Is there a history of alcohol or substance abuse? If Yes, the patier is actively using has been in remission for months7. Fraud Notice	nt (please check one): years
	Physician's Last name
	triysician's East name trysician's East name trysician's East name trysician's East name trysician's East name
City	State ZIP Code
Specialty Telephone number Any person who knowingly and with intent to injure, defraud, or deceive any insura commission of a fraud, submits incomplete, false, fraudulent, deceptive or mislea a statement of claim for payment of a loss or benefit commits a fraudulent insura punished under state law. Penalties include fines, civil damages and criminal pen deny insurance benefits if false information materially related to a claim was provinisleading, information concerning any fact material thereto.	ding facts or information when filing an insurance application or nce act, is/may be guilty of a crime and may be prosecuted and alties, including confinement in prison. In addition, an insurer may
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
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