GROUP LIFE - Waiver of Premium / Permanent Total Disability (PTD) / Disability Extension Claim Form

ABACUS SERIES™
Underwritten by KANSAS CITY LIFE INSURANCE COMPANY

INSTRUCTION PAGE

Claim form to waive premium on Group Life Insurance for covered employees who have become disabled and are unable to work.

Why apply for Group Life Waiver of Premium?

If employees become disabled as defined by their Group Life plan, the Waiver of Premium benefit, featured on many of Abacus Life Insurance policies, offers a safeguard against losing valuable Group Life coverage. For employees who apply and are approved, no Group Life premiums are due after the Waiver of Premium waiting period has been satisfied, and coverage continues in accordance with the policy provisions. ****Reminder** Group Life Premiums are due and payable during the Waiver of Premium waiting period unless the employee has already converted coverage to an individual policy.**

EMPLOYER'S RESPONSIBILITY - SECTION 1

1. Detach and complete the Employer Section. Sign and date the Employer's Section. Without this information, the claim process cannot continue.

2. If any portion of the Group Life coverage was elected, please attach a copy of the enrollment history for all benefit elections elections.

3. Attach a copy of the most recent Beneficiary Designation Form.

4. Give the remaining sections of the form, including this instruction sheet, to your employee. Ask him or her to complete the Employee Sections and return the claim form to Abacus. (Your employee should detach the *Attending Physician's Statement of Disability,* Attending Physician's Statement, pages 1 through 4, and forward to his/her physician for completion.)

5. SUBMIT THE EMPLOYER'S STATEMENT & ATTACHMENTS DIRECTLY TO THE ABACUS BEFORE THE 12-MONTH DEADLINE.

EMPLOYEE'S RESPONSIBILITY - SECTION 2

1. Complete Employee Section - pages 1 and 2. Sign and date the claim form on Employee Section - page 3.

2. Read and complete Employee Section 2 - page 4. Sign and date the authorization at the bottom of the Employee Section 2 - page 4.

3. On the *Attending Physician's Statement of Disability*, complete and sign the Employee information and authorization at the top of the Attending Physician's Statement - page 1. Remove the *Attending Physician's Statement of Disability Section* (Attending Physician's Statement) - pages 1 through 4 from this claim form and give it to the physician certifying your disability. Ask your physician to complete the form and return it within 10 days to Abacus. Be aware that you are responsible for any fees charged by your physician for completion of this form.

4. SUBMIT THIS APPLICATION BEFORE THE 12-MONTH DEADLINE* To qualify for benefits, submit the completed Employee Sections and all attachments, by the deadline* specified in your Group Life plan. Make a copy to keep with your records. The *Attending Physician's Statement* should be sent separately by the physician before the same deadline. The Employer section should be sent separately before the same deadline.

5. Please follow up to make sure that this claim form, all attachments, and the *Attending Physician's Statement of Disability* are received by Abacus within the deadline* specified in your Group Life plan.

SEND THE CLAIM FORM TO:

Abacus Series
Group Claims Department
P. O. Box 14294
Lexington, KY 40512-4294

OR FAX TO:

Group Benefit Claims
Fax Number: (855) 864-0530

For questions about how to complete this form, call Abacus Toll-free at **(866) 590-7448**

***The deadline for submission is usually 12 months from the employee's date last worked; check your plan to verify.**

Please verify if the employee qualifies for any other group benefits through Abacus and submit the claim accordingly.

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Clear Form

EMPLOYER SECTION 1

This is a time-sensitive document (submission deadline is usually 12 months from date last day worked; check your plan)

***Please verify if the employee qualifies for any other group benefits through Abacus and submit the claim accordingly.**

A. INFORMATION ABOUT YOUR COMPANY

Company Name

Address (Street, City, State, Zip Code)

Name and address of division where employee works, if different from above:

Group Policy Number	Telephone Number ( )	Fax Number ( )	E-Mail address

B. INFORMATION ABOUT YOUR EMPLOYEE

Employee's Name	Social Security Number	Date of Birth

Address (Street, City, State, Zip Code)	Telephone Number ( )

Date hired: ☐ Full time ☐ Part time	Date Group Life Insurance became effective: _____	Last day worked: _____	Premiums paid to date? ☐ Yes ☐ No

Employee Division ☐ Exempt ☐ Non-exempt ☐ Salaried ☐ Hourly

Group Life: Insurance coverage amount: **Basic Life $** _____ **Supplemental Life $** _____

(Attach enrollment forms & beneficiary form.)

Permanent Total Disability Benefits:

Amount of **Basic Life** Insurance $_____ Amount of **Supplemental Life** Insurance $ _____

Amount of Permanent Total Disability requested $ _____ Number of hours scheduled to work weekly _____

Rate of Annual Basic Earnings on date last worked: $ _____ per ☐ Hour ☐ Week ☐ Month ☐ Year

(Attach W-2, if applicable)

Do earnings include commissions, bonuses or overtime? ☐ Yes ☐ No If "Yes," please specify:

Are employee's eligible dependents covered by Waiver of Premium benefits? ☐ Yes ☐ No If "Yes," please provide amounts of Group Life coverage and enrollment history:

Spouse's Name:_____ Date of Birth: _____ Coverage Amount: _____

Child's Name: _____ Date of Birth: _____ Coverage Amount: _____

Child's Name: _____ Date of Birth: _____ Coverage Amount: _____

Has employment been terminated/retired? ☐ Yes ☐ No If "Yes," date: _____

Was an application for conversion offered? ☐ Yes ☐ No

C. INFORMATION ABOUT THE DISABILITY

Before the employee became totally disabled, were any changes made to the employee's job responsibilities because of the disabling condition? ☐ Yes ☐ No. If "Yes," what were the changes and when were they made? _____

What was the employee's permanent job or occupation title on his or her last day at work? _____

How long had the employee been in this job? _____	Full time? ☐ Yes ☐ No
Date employee is expected to, or did return to work: _____	Why did employee stop working? _____

Is the cause of employee's condition work related? ☐ Yes ☐ No

Is your employee receiving income from other sources? e.g.: ☐ Short Term Disability ☐ Long Term Disability ☐ Workers' Compensation ☐ Social Security **(If applicable, provide name and address of insurance carrier:)**

D. REQUIRED ATTACHMENTS AND SIGNATURE

For Voluntary Group Life Insurance coverage, attach a copy of the enrollment form history and/or copies of the Electronic Benefits (screen prints). I hereby certify that the information provided in the Employer's Section is true and complete to the records of the Employer, I agree that this information is subject to audit by Abacus and/or its representatives.

Name *(Please print or type)*	Title
	( )
Signature of Employer Representative	Date / Telephone Number

GROUP LIFE - Waiver of Premium / Permanent Total Disability (PTD) / Disability Extension Claim Form

ABACUS SERIES™ Underwritten by KANSAS CITY LIFE INSURANCE COMPANY

EMPLOYEE SECTION 2

This is a time-sensitive document

***Submission deadline is usually 12 months from the last day of work; check your plan.**

Group Policy Number: _____

Employer Name: _____

Be sure to answer all questions - missing information may delay your claim.

A. INFORMATION ABOUT YOU

Name:

Address:

Telephone Number: ( ) _____ | ☐ Male ☐ Female | E-Mail address: _____

At the time your TOTAL disability began, were you working more than one job (including self-employment)? ☐ Yes ☐ No
If "Yes," provide the name, address and phone number of other employers and indicate the dates when you worked (or were self-employed).

Please indicate your educational history: (Check or Circle last year completed.)

Education through High School
1 2 3 4

College
1 2 3 4

☐ Masters ☐ Ph.D.

Are you now attending school? ☐ Yes ☐ No

Trade or technical school: (Describe course of study .)

_____

_____

_____

Describe your last four jobs. (Begin with your most recent job.)

	Company	Job Title	Duties	Years
(a)				
(b)				
(c)				
(d)				

Are you receiving any income from other sources?

	Amount	Name	Address	Phone
Short Term / Long Term Disability	$			( )
Workers' Compensation	$			( )
Individual Disability	$			( )
Self-employment or Part-time work	$			( )

B. INFORMATION ABOUT THE CONDITION CAUSING YOUR DISABILITY

Describe your medical condition: _____

Why did you stop working? _____

If caused by an illness, have you had this illness before? ☐ Yes ☐ No If "Yes," when? _____

If caused by an injury, when, where and how did the injury occur? _____

Date you were first treated by a Medical Provider for the disabling illness or injury: _____

Name of Medical Provider:

Before you stopped working, did your condition require you to change your job or the way you did your job? ☐ Yes ☐ No
If "Yes," explain:

What aspect of your condition made you unable to work?

Is the cause of your condition related to your job? ☐ Yes ☐ No If "Yes," explain: _____

What important duties of your job are you unable to perform? _____

Are you now engaged in the duties of any occupation or endeavor for wages, profit, compensation or volunteerism? ☐ Yes ☐ No

C. INFORMATION ABOUT YOUR DISABILITY

Last day you physically reported to work: _____ Since that date, have you done any work? ☐ Yes ☐ No
If "Yes," please indicate dates worked, name and address of employer and amount earned.

Have you returned to work in any capacity? ☐ Yes ☐ No If you have not returned to work, do you expect to? ☐ Yes ☐ No

If "Yes," part-time *(date)* _____ full-time *(date)* _____

D. INFORMATION ABOUT YOUR PHYSICIANS

List all physicians you have seen for this condition *(attach a separate sheet if needed)*

Doctor's Name _____ Specialty _____ Dates seen _____

Address _____

City/State/Zip Code _____ ( ) Telephone Number _____ ( ) FAX Number _____

Doctor's Name _____ Specialty _____ Dates seen _____

Address _____

City, State, Zip Code _____ ( ) Telephone Number _____ ( ) FAX Number _____

Doctor's Name _____ Specialty _____ Dates seen _____

Address _____

City, State, Zip Code _____ ( ) Telephone Number _____ ( ) FAX Number _____

IMPORTANT NOTICE

E. EMPLOYEE'S SIGNATURE

Please read the statement that applies to your state of residence and sign the bottom of the page.

For residents of all states EXCEPT California, Colorado, Florida, Kentucky, Maine, Maryland, New Jersey, New York, Oregon, Pennsylvania, Puerto Rico, Tennessee, Virginia and Washington: 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.

For Residents of California: For your protection, California law requires the following to appear on this form: Any person who knowingly presents 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.

For residents of Colorado: 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 award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

For residents of Florida: 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.

For residents of Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim or an application for insurance 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.

For residents of Maine, Tennessee, Virginia and Washington: 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 and denial of insurance benefits.

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

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

For residents of New York: 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 also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

For residents of Oregon: 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 is subject to a denial and/or reduction in insurance benefits and may be subject to any civil penalties available.

For residents of Pennsylvania: 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 hereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

For residents of Puerto Rico: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

The statements contained in this application for Group Life Waiver of Premium / Permanent Total Disability / Disability Extension Application are true and complete to the best of my knowledge and belief.

Signature _____ Date _____

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

To: Any health care provider, employer, benefit plan, insurer, service provider, financial institution, consumer reporting agency, educational institution, or Federal, State, or Local Government Agency, including the Social Security Administration and Veterans Administration. **I AUTHORIZE** you to disclose to Abacus a complete copy of any and all of the following personal or privileged information, records, or documents relative to:

Insured's Name (*Please print*)	Date of Birth	Last 4 Digits of Social Security Number

Any and all medical information or records, including x-ray films, medical histories, physical, mental, or diagnostic examinations, and treatment notes, and including information regarding HIV/AIDS, communicable diseases, alcohol or drug abuse, and mental health; work information and history, including job duties, earnings, personnel records, and client lists; information on any insurance coverage and claims filed, including all records and information related to such coverage and claims; credit information, including credit reports and credit applications; other financial information, including pension benefits and bank records; business transactions billing, invoice, and payment records; academic transcripts; and information concerning Social Security benefits, including monthly benefit amounts, monthly payment amounts, entitlement dates, and information from my Master Beneficiary Record. The information obtained by use of this Authorization will be used for the purpose of evaluating and administering my claim for benefits and/or leave request. Such information shall be referred to herein collectively as "My Information." I understand I have the right to revoke this Authorization for future disclosures, except to the extent action has been taken in reliance upon this Authorization. I must revoke this Authorization in writing directly to Abacus.

I UNDERSTAND that once My Information has been disclosed to Abacus as permitted under this Authorization, it may be re-disclosed by Abacus as permitted by law or my further authorization. I authorize Abacus to use or disclose My Information (i) to my employer for a) functions related to accommodating my disability; b) responding to claims related to accommodation or adverse or discriminatory treatment related to my claim; c) responding to complaints by me or my representative relating to benefits or leave; d) responding to any litigation or agency document production request or lawful subpoena; e) federal, state, or other leave administration; f) fulfilling fiduciary obligations under my benefit plan; or (g) claim or other audits or reviews; (ii) to the administrator or other service providers of my employer 's benefit plan, other benefits, and/or leave programs of my employer for plan, benefit, or program related functions or data aggregation and analysis; (iii) to any claim system used for claims processing or insurance broker to carry out functions related to my benefit plan or claim; (iv) to any health care professional who has treated or evaluated me or who may do so; (v) to other persons or entities performing business, medical, or legal services related to my claim; (vi) for other insurance or reinsurance purposes, including workers' compensation insurance; (vii) as may be lawfully required; (viii) as may be reasonably necessary to protect the personal safety of others; or (ix) as may be reasonably necessary to prevent or detect perpetration of a fraud.

I ALSO UNDERSTAND that information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient. I understand that I have the right to revoke this Authorization for future disclosures Abacus may make, unless Abacus has taken action in reliance upon this Authorization. I must revoke this Authorization in writing directly to Abacus. I understand that my medical treatment or payment for medical benefits cannot be conditioned on my allowing Abacus to re-disclose My Information. The authorizations set forth herein expire two years from the date listed below, or upon my revocation, if earlier, but will not exceed the term of my coverage under the policy(ies) or benefit plan or program, except as may be reasonably necessary to prevent or detect perpetration of a fraud or protect the personal safety of others. I understand that I am entitled to receive a copy of this Authorization upon request. A photocopy or facsimile of this Authorization shall be as valid as the original. If there is a conflict between a prior request for restriction on the disclosure of My Information and this Authorization, this Authorization will control.

Signature of Insured or Guardian	Date	Relationship to Insured (*if signed by Guardian*)

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ATTENDING PHYSICIAN'S STATEMENT
This is a time-sensitive document

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Submission deadline is usually 12 months from the last day of work; check your plan.

The employee is responsible for any physician fees for the completion of this form.
This section to be completed and signed by the Employee

Name of Patient

Address *(Street)*

(City/State/Zip Code)

( ) Telephone Number | Date of Birth | Social Security Number

Employer and Division *(if applicable)*

I hereby authorize my physician to release any information concerning my medical condition(s) for the purpose of claim process ing.

Patient's Signature | Date

Physician's Instructions **Please respond within 10 Days**

A delay in returning a completed *Attending Physician's Statement* could result in your patient's being disqualified from receiving valuable Life Insurance benefits.

Please complete the remainder of this form for your patient. Sign and date the last page.

SEND THE COMPLETED FORM TO:
ABACUS SERIES
Group Claims Department
P. O. Box 14294
Lexington, KY 40512-4294

OR FAX TO:
Group Benefit Claims
(855) 864-0530

If you have questions, call The Hartford Toll-free at (866) 590-7448

This section to be completed by the Attending Physician

A. PATIENT INFORMATION

Height _____ Weight _____

Patient's condition is the result of: ☐ Illness ☐ Injury ☐ Pregnancy ☐ Other

Is condition due to illness or an injury that is work related? ☐ Yes ☐ No

B. DIAGNOSIS

Primary diagnosis _____ ICD-9 Code _____

Secondary diagnosis(es) _____ ICD-9 Code _____

Concurrent/Co-morbid conditions(s) _____ ICD-9 Code _____

Subjective symptoms: _____

Objective findings: _____

C. TREATMENTS

Date you first treated this patient _____ | Date you first treated this patient for this condition _____

Date Patient was first advised to stop working due to Illness/Injury _____

Date of onset of this condition _____ Date of most recent treatment _____

How often has patient been seen or treated? _____ Date of next office visit. _____

Has patient been referred to any other physician? ☐ Yes ☐ No
If "Yes":

Physician's name _____ Physician's Telephone Number (____) _____

Physician's address _____

Specialty _____ Date of office visit _____

Nature of treatment for this condition _____

Has surgery been performed? ☐ Yes ☐ No If "Yes", Date _____

Procedure _____ CPT Code: _____

_____ _____

Was patient hospitalized for this condition? ☐ Yes ☐ No If "Yes,"

Name and address of hospital(s) _____

Date(s) admitted _____ Date(s) discharged _____

Progress (please check one) ☐ Recovered ☐ Improved ☐ Unchanged ☐ Retrogressed

D. PHYSICAL IMPAIRMENTS

1. Indicate the extent to which the p atient's ability to perform any of the following activities is limited by his or her disor der.
In an 8-hour workday , the patient can *(Circle or check number of hours)*:

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

2. Check the maximum limit and frequency that the patient can lift/carry:

	Never	Occasionally	Frequently	Constantly
1-10 lbs.	☐	☐	☐	☐
11-20 lbs.	☐	☐	☐	☐
21-50 lbs.	☐	☐	☐	☐
51-100 lbs.	☐	☐	☐	☐
over 100 lbs.	☐	☐	☐	☐

D. PHYSICAL IMPAIRMENTS (cont'd)

3. Check the maximum limit and frequency that the patient can lift/carry:

	Never	Occasionally	Frequently	Constantly
Climbing	☐	☐	☐	☐
Balancing	☐	☐	☐	☐
Stooping	☐	☐	☐	☐
Kneeling	☐	☐	☐	☐
Crouching	☐	☐	☐	☐
Crawling	☐	☐	☐	☐
Reaching				
Above shoulder	☐	☐	☐	☐
Below waist level	☐	☐	☐	☐
At waist level	☐	☐	☐	☐
Handling	☐	☐	☐	☐
Fingering	☐	☐	☐	☐
Feeling	☐	☐	☐	☐

4. Indicate the patient's capacity for repetitive use of feet and hands.

Right hand ☐ Yes ☐ No Left hand ☐ Yes ☐ No Both hands ☐ Yes ☐ No

Right foot ☐ Yes ☐ No Left foot ☐ Yes ☐ No Both feet ☐ Yes ☐ No

4a. Dominant hand (check one) ☐ Right ☐ Left

5. If any other activities are limited, please specify the activities and the limitations

6. If the patient's vision is impaired, please describe the extent of the impairment _____

Date vision test was performed _____

Visual Acuity:	R	L
Corrected		
Non-Corrected		

7. From the following classifications of work strength requirements, please describe the exact degree of work you feel this patient is capable of performing*: _____

☐ **Sedentary Work:** Lifting 10 lbs. maximum and occasionally lifting and/or carrying articles such as dockets, ledgers and small tools. A job is considered sedentary if it involves primarily sitting, and requires only occasional walking and standing.

☐ **Light Work:** Lifting 20 lbs. with frequent lifting and/or carrying of objects weighing up to 10 lbs. A job is considered Light Work if it involves sitting most of the time with a degree of pushing and pulling or use of arm and/or arm controls; or when it requires walking or standing to a significant degree.

☐ **Medium Work:** Lifting 50 lbs. maximum with frequent lifting and/or carrying of objects weighing up to 25 lbs.

☐ **Heavy Work:** Lifting 100 lbs. maximum with frequent lifting and/or carrying of objects weighing up to 50 lbs.

☐ **Very Heavy Work:** Lifting more than 100 lbs. with frequent lifting and/or carrying of objects weighing 50 lbs or more.

***Five degrees of work are taken from the Dictionary of Occupational Titles, Volume II, pages 654-655, published by the U.S. Dept of Labor (3rd ed. 1965)**

8. Are there environmental workplace restrictions for this patient as a result of the patient's impairment? ☐ Yes ☐ No
"If Yes," describe:

9. CARDIAC (complete if disability is due to heart condition) ☐ Class 1 (No limitation) ☐ Class 2 (Slight limitation)
☐ Class 3 (Marked limitation) ☐ Class 4 (Complete limitations)

Remarks: _____

E. PSYCHIATRIC IMPAIRMENTS (if applicable)

What problems with stress or interpersonal relations has the patient had on the job? Indicate the degree to which the patient is able to perform the duties of their occupation.

☐ **Class 1 - No Limitations:** Patient is able to function under stress and engage in interpersonal relations.

☐ **Class 2 - Slight Limitations:** Patient is able to function in most stress situations and engage in only limited interpersonal relations.

☐ **Class 3 - Moderate Limitations:** Patient is able to engage in stress situations or engage in only limited interpersonal relations.

☐ **Class 4 - Marked Limitations:** Patient is unable to engage in stress situations or engage in interpersonal relations.

☐ **Class 5 - Severe Limitations:** Patient has significant loss of psychological, physiological, personal and social adjustment.

Do you believe the patient is competent to endorse checks and manage the proceeds appropriatley? ☐ Yes ☐ No

Remarks: _____

_____

GAF Score: _____ Date: _____

What are the stressors? _____

Job Related? ☐ Yes ☐ No

F. OUTLOOK

Has the patient reached maximum medical improvement ☐ Yes ☐ No

Date patient can return to work at his/her regular job: _____
Month Day Year

Specify: ☐ Without restrictions
☐ With restrictions, as noted

Date patient can return to work at a different job in a lighter duty capacity _____
Month Day Year

How long do you expect the restrictions and limitations from any work to continue? _____

G. PHYSICIAN INFORMATION

Physician's Name: _____ Social Security Number or EIN _____

Address: *(Street, City, State, Zip Code)* _____

Specialty _____ Licence Number _____ ( ) Telephone Number _____ ( ) Fax Number _____

Physician's Signature _____ Date _____

PLEASE ATTACH OFFICE NOTES, CONSULTATION REPORTS, OR ANY DIAGNOSTIC TESTS THAT ILLUSTRATE CURRENT LIMITATIONS AND RESTRICTIONS.