ATTENDING PHYSICIAN'S STATEMENT OF DISABILITY

Standard Security Life Insurance Company
Independence Holding Group

c/o North American Benefits Company
P.O. Bo 3056
Southeastern, PA 19398-3056
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Any person who knowingly and with intent to defraud any insurance company or other person files a statement 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

Name of Patient	Date of Birth
Present Address	
Employers Name	Group Policy No.

We must have comprehensive medical information in order to evaluate the insured's claims for Disability Benefits. Any charge required for completion of the this form is the responsibility of the patient.

1. HISTORY

When symptoms first appeal or accidents happen? Mo. Day Yr.

Date disability commenced Mo. Day Yr.

Has patient ever had same or similar condition? ☐Yes ☐No

If "Yes", state when and describe _____

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

2. DIAGNOSIS (including any complications)

Diagnosis (including any complications)_____

Subjective symptoms _____

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

3. DATES OF TREATMENT

Date of fist visit Mo. Day Yr.

Date disability commenced Mo. Day Yr.

Frequency
☐Weekly ☐Monthly ☐Other(specify)_____

4. NATURE OF TREATMENT

Please describe course of treatment. _____

5. PROGRESS

Give prognosis with reasonable estimate of return to work date. _____

Has patient been hospital confined? ☐Yes ☐No

If "Yes" Give Name and Address of Hospital | Confined from | through

6. CARDIAC (If Applicable)

Functional capacity (American Heart Ass'n) ☐Class 1 (No limitation) ☐Class 2 (Slight limitation) ☐Class 3 (Marked limitation) ☐Class 4 (Complete limitation)

Blood Pressure (last visit)_____

Results of stress test _____

7. LIMITATION (If there is a limitation, check and describe)

☐Standing	☐Climbing	☐Bending	☐Use of Hands	☐Sitting
☐Walking	☐Stooping	☐Lifting	☐Other	

8. 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 (60-70%)
☐Class 5 – Severe limitation of functional capacity; incapable of minimal (sedentary*) activity (75-100%)

Remarks: _____

9. MENTAL/ NERVOUS IMPAIRMENT (if applicable)

Please define "stress" as it applies to this claimant.
☐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 most 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: _____

Do you believe the patient is competent to endorse checks and direct the use of proceeds thereof? ☐Yes ☐No

10. EXTENT OF DISABILITY

Is Patient now totally disabled?	**From Any Occupation** ☐Yes ☐No			**From Patients Regular Occupation** ☐Yes ☐No		
If yes, when do you think patient will be able to resume any work? *Approximate Date*	Mo.	Day	Yr.	Mo.	Day	Yr.

11. REHABILI-TATION

When could trial employment commence?	**Patient's Job**			**Any Other Work**		
	Mo.	Day	Yr.	Mo.	Day	Yr.

Describe rehabilitation needs: _____

12. REMARKS _____

Signature (attending Physician) Date

Name of Physician (please print): Telephone

Address (Street, City or Town, State or Province, Zip Code)