

To Be Completed By Employee

Full Name		
Educational Entity		Group Policy No. 646595

To Be Completed By The Attending Physician

The following information is needed to document the patient's inability to work. The patient is responsible for obtaining a complete form without expense to The Standard. Please complete this form and mail or fax it to The Standard using the contact information listed above.

1. Diagnosis	A. Diagnosis			ICDA Classification
B. Symptoms			Height	Weight B/P
2. Pregnancy (if applicable)		A. Expected date of delivery	B. Actual date of delivery	<input type="checkbox"/> Vaginal <input type="checkbox"/> C-section
3. History and Treatment		A. Date you recommended the patient stop work		B. When did symptoms appear or accident happen?
C. Has the patient ever had the same or similar condition? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when?				
D. Is this condition related to the patient's employment?		<input type="checkbox"/> Yes <input type="checkbox"/> No	E. Did you complete a Workers' Compensation claim form? <input type="checkbox"/> Yes <input type="checkbox"/> No	
F. Date of first visit for this condition		G. Frequency of subsequent visits: <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other _____		H. Date of most recent visit
I. Describe planned course and duration of treatment				
J. Hospitalization? <input type="checkbox"/> Yes <input type="checkbox"/> No	K. Date Admitted	Date Discharged	L. Surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No	M. Date Surgery Completed/Scheduled
N. Reason/Surgery Type		O. Surgery/Post-Surgery Complications? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe		
4. Level of Functional Impairment <i>Please attach recent chart notes/pertinent records.</i>				
A. Describe patient's physical and/or mental limitations and restrictions (functional capacity).				
B. Factors Delaying Recovery (if applicable)				
C. How long do you expect these limitations and restrictions to impair your patient? <input type="checkbox"/> Date _____ <input type="checkbox"/> Unable to determine, follow up in _____ weeks <input type="checkbox"/> Permanently				
D. Is the patient competent to manage insurance benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, is the patient competent to appoint someone to help manage the insurance benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No				
5. Physician Information <i>Please type or print.</i>				
Name of physician completing this form		Specialty		Phone No. ()
Address		City	State	ZIP
				Fax No. ()
Acknowledgement – I certify that the answers I have made to the above questions are complete and true to the best of my knowledge and belief. I acknowledge that I have read the fraud notice on page 2 of this form.				
Signature _____		Date _____		

Some states require us to provide the following information to you:

CALIFORNIA RESIDENTS

For your protection, California law requires 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.

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 the 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.

DISTRICT OF COLUMBIA RESIDENTS

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

FLORIDA RESIDENTS

Any person who knowingly and with intent to injure, defraud or deceive an insurance company, files a statement of claim or an application containing false, incomplete or misleading information is guilty of a felony of the third degree.

MARYLAND AND RHODE ISLAND 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.

NEW JERSEY RESIDENTS

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NEW YORK 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 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.

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.

ALL OTHER RESIDENTS

Some states require us to inform you that any person who knowingly and with intent to injure, defraud or deceive an insurance company, or other person, files a statement containing false or misleading information concerning any fact material hereto commits a fraudulent insurance act which is subject to civil and/or criminal penalties, depending upon the state. Such actions may be deemed a felony and substantial fines may be imposed.