Reset

Standard Insurance Company
PO Box 3877 Portland OR 97208 866.756.8116 Tel 866.751.5174 Fax

Disability Benefits/Family Medical Leave
Attending Physician's Statement

Claim #:	
To:	Policyholder:

*Federal law requires us to notify you that sections marked with * are required for purposes of completing your disability claim. Please complete Part A and have your attending physician complete Part B. Failure to answer questions may delay the processing of your claim for benefits. If you need assistance, please contact our office.*

PART A. TO BE COMPLETED BY PATIENT

*1. I verify my medical condition prevents me from working on _____ /_____ /_____ (today's date), or

*2. I returned to work on _____ (check all that apply) ☐ my job ☐ another job ☐ self-employed ☐ I expect to return to work on _____

I certify the above answers are true and complete and form the basis of my claim for disability benefits.

***Some states require us for your disability claim 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.**

Signature _____ Phone No. _____ Date _____

The patient is responsible for the completion of this form without expense to Standard Insurance Company.

PART B. TO BE COMPLETED BY PHYSICIAN

DEAR DOCTOR:
The purpose of this form is to help us determine whether the clinical condition of your patient continues to be disabling. Please advise of any clinical findings including laboratory data and results of special tests such as X-rays, CAT scan, EKG, etc. Copies of any surgical reports, hospital discharge summaries, chart notes, or narrative reports will be helpful.

1. Date of most recent visit _____ Frequency of visits: ☐ Weekly ☐ Monthly ☐ Other _____ If pregnancy, date of delivery _____

2. Patient's condition since last report to The Standard (or date of first visit) whichever is later: *Ht. _____ *Wt. _____ *BP. _____
(Please check one) ☐ Recovered ☐ Improved ☐ Unchanged ☐ Regressed

3. Primary diagnosis: _____ ICD code _____

Secondary diagnosis: _____ ICD code _____

4. Describe patient's physical and mental limitations and work activity restrictions for period: _____ to _____

*Is this patient competent to manage insurance benefits? ☐ Yes ☐ No

*If no, is the patient competent to appoint someone to help manage the insurance benefits? ☐ Yes ☐ No

5. Planned course of treatment (include expected duration, surgeries, etc.): _____

6. Medications prescribed and dates of prescription: _____

7. If patient was recently hospitalized, Name of hospital: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Admitted: _____ Discharged: _____

8. When do you anticipate the patient can return to work? Anticipated date: _____ or, Unable to determine, follow up in _____ months

Remarks: _____

*Other physicians being consulted: _____

Name of physician completing this form:	Speciality:		
Address:	City:	State:	Zip Code:
Phone No.:	Taxpayer Identification No.:		

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Signature _____ Date _____

When both parts A and B have been completed, return to the address indicated above.

Print (6/09)