Standard Insurance Company

Employee Benefits Department 800.368.1135 Tel 971.321.8400 Fax
PO Box 2800 Portland OR 97208

WA Health Care Authority
School Employees Benefits Board (SEBB) Program
Long Term Disability Insurance
Attending Physician's Statement

Reset

Part A. To Be Completed By Patient

Full Name _____ Social Security No. _____

Other Names Used _____

Address _____ City _____ State _____ ZIP _____

Phone No. (_____) _____ Birthdate _____ Patient No. _____

Occupation _____ Employer WA Health Care Authority School Employees Benefits Board (SEBB) Program Group Policy No. 756494

I returned to work: Date _____ I expect to return to work: Date _____

Part B. To Be Completed By Physician

The purpose of this form is to help us determine whether the clinical condition of your patient is disabling. We need documentation of functional impairment. Please include laboratory data and results of special tests (X-rays, CAT scan, EKG, etc.). Please attach copies of any pertinent surgical reports, hospital admitting history, physician discharge summaries, chart notes, and narrative reports.

The patient is responsible for the completion of this form without expense to The Standard. Forms may be returned for unanswered questions.

1. Information

Primary Diagnosis: ICD Code (_____) _____

Secondary Diagnosis: ICD Code (_____) _____

Other diagnoses and ICD Codes related to this claim.

Symptoms

Patient's Height _____ Weight _____ BP _____ (Right Arm) BP _____ (Left Arm) Pulse _____ (Radial)

Is condition primarily related to:

a. Patient's Employment ☐ Yes ☐ No
b. Mental Disorder ☐ Yes ☐ No
c. Alcohol or Drug Condition ☐ Yes ☐ No
d. Pregnancy ☐ Yes ☐ No

Dominant Hand ☐ Left ☐ Right

Expected Delivery Date _____

Para _____ Gravida _____

Actual Delivery Date _____

Complications _____

☐ Vaginal ☐ Caesarean Section

2. History

If patient was referred to you, indicate by whom _____

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

If yes, indicate when _____ Describe _____

Do, or have, other conditions contributed to this condition? ☐ Yes ☐ No

If yes, please explain _____

Date patient first consulted you for **this** condition _____ For **any** condition _____

Dates of subsequent treatment _____

Date of most recent visit _____

Was the patient hospitalized? ☐ Yes ☐ No If yes, ☐ Inpatient ☐ Outpatient Date Admitted _____ Date Discharged _____

Admitting Diagnosis _____ Discharge Diagnosis _____

Name of Hospital _____

Address _____ City _____ State _____ ZIP _____

Standard Insurance Company

Employee Benefits Department 800.368.1135 Tel 971.321.8400 Fax
PO Box 2800 Portland OR 97208

WA Health Care Authority
School Employees Benefits Board (SEBB) Program
Long Term Disability Insurance
Attending Physician's Statement

Claimant's Name _____

3. Assessment

Date you recommended patient should stop working _____ Why? _____

Describe the patient's physical, mental and cognitive limitations and work activity limitations _____

How long from today's date will the described limitations impair the patient? _____

Is the 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

4. Treatment

Planned course of treatment. ***Please include expected duration, surgeries, therapy, etc.*** _____

Medications prescribed: dosage, frequency and date of prescription(s). _____

List other treating or referring physicians. ***Continue on separate page, if necessary.***

Name	Address		
1.			
Phone No. ( )	City	State	ZIP
2.			
Phone No. ( )	City	State	ZIP

What reasonable work or job site modifications could the employer make to assist the individual to return to work? ***Please specify.***

Assessment and treatment are complicated by:

☐ Malingering

☐ Significant emotional or behavioral disorder such as: ☐ Depression ☐ Anxiety ***Check pertinent areas.***

☐ Exaggeration, inconsistent findings, subjective complaints out of proportion to objective findings, bizarre or contradictory observations.

☐ Dependence on drugs/medication. ***Please specify.*** _____

☐ Other ***Please describe.*** _____

5. Prognosis

Describe patient's condition since onset of symptoms: ☐ Recovered ☐ Improved ☐ Unchanged ☐ Regressed
When do you expect a fundamental or marked change in patient's condition? ☐ Never ☐ Condition expected to regress ☐ Condition expected to improve

State anticipated date _____ or, Unable to determine, follow up in _____ months

When do you anticipate the patient can return to work? State anticipated date _____ or, Unable to determine, because of _____

_____ follow up in _____ months

Remarks _____

6. Acknowledgement

I hereby certify that the answers I have made to the foregoing questions are both complete and true to the best of my knowledge and belief. I acknowledge that I have read the applicable fraud notice on page 3 of this form.

Physician's Signature _____ Date _____

Physician's Name (Please Print) _____ Specialty _____

Address _____ City _____ State _____ ZIP _____

Physician's Taxpayer ID No. _____ Phone No. (_____) _____ Fax No. (_____) _____

Return to Standard Insurance Company at the address above.

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

ALABAMA, MARYLAND AND RHODE ISLAND RESIDENTS

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.

CALIFORNIA RESIDENTS

For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a 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.

NEW HAMPSHIRE RESIDENTS

Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

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 MEXICO RESIDENTS

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 civil fines and criminal 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 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.

TEXAS RESIDENTS

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.

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.