Reset

The Standard Life Insurance Company of New York

PO Box 5031 White Plains NY 10601-5031 855.977.7764 Tel

Stay At Work
Medical Information Request

Dear Employee: Please complete this section.

Employee Name _____ Birth Date _____

Employer _____

Dear Attending Physician: The purpose of this request is to help us determine whether we will be able to assist the patient to remain at work. ***Please include results of diagnostic testing and pertinent chart notes.***

1. Diagnosis (include the ICD code)_____

_____

Date of most recent visit_____ Frequency of visits _____

Expected duration of impairment from this condition _____

2. Describe patient's current symptoms, physical limitations and work activity restrictions_____

_____

_____

3. Planned course of treatment (include expected duration) _____

_____

_____

4. Do you have recommendations for workstation modifications/accommodations that will assist the patient to perform his/her job? ☐ Yes ☐ No

If yes, please list them _____

_____

How will the modifications/accommodations help the patient perform the functions of his/her job? _____

_____

_____

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.

Physician's Signature		Date	
Physician's Name (please print)		Specialty	
Address	City	State	ZIP
Phone No.	Fax No.		

Please fax completed form to: 971-321-5727/855-207-6115

Print