Standard Insurance Company

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

Long Term Disability Insurance Attending Physician's Statement

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 ______ Group Policy No. ______

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 ______

If patient was hospitalized, please provide dates. Admitted ______ Discharged ______

Admitting Diagnosis ______ Discharge Diagnosis ______

Name of Hospital ______

Address ______ City ______ State ______ ZIP ______

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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 ☐ Hysteria *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 12 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.