

**HARTFORD LIFE INSURANCE COMPANY  
HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY**



**ATTENDING PHYSICIAN STATEMENT OF CONTINUED DISABILITY**

Name of Patient:	Date of Birth:	Social Security Number:
Address of Patient: (Street, City, State & Zip Code)	Employer:	
I hereby authorize release of information on this form by the below named physician for the purpose of claim processing.		
Signed: _____		Date: _____

**To be completed by the Attending Physician - Use current information from your patient's most recent examination or office visit to complete this form. (The patient is responsible for the completion of this form without expense to the Company.)**

**DIAGNOSIS**

Primary Diagnosis:	ICD-9 Code:
Secondary Diagnosis:	ICD-9 Code
Was Surgery Performed: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Date _____ Procedure _____ CPT-4 Code _____	
Was patient hospitalized since last report? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Admission Date _____ Discharge Date _____	
Current Subjective Symptoms:	
Current Physical Exam findings:	
Tests (Not previously reported):	Dates
Results (or enclose copies of test result report):	
Medication (indicate any changes):	

**FUNCTIONALITY (This information is required for evaluation of your patient's claim for disability benefits).**

List all restrictions and/or limitations based on medical findings. (Example - No standing over 4 hours; No lifting over 50 lbs)

\_\_\_\_\_

Is patient able to return to work without restrictions?  Yes  No If "Yes," Date: \_\_\_\_\_  Full Time  Part Time \_\_\_\_\_ hours per day

Is patient able to return to work with restrictions?  Yes  No If "Yes," Date: \_\_\_\_\_  Full Time  Part Time \_\_\_\_\_ hours per day

If able to return to work only part time, on what date will he / she be able to increase to full time? \_\_\_\_\_

How long are these work accommodations expected to be in place? \_\_\_\_\_

**TREATMENT**

Changes in Treatment Plan:	<input type="checkbox"/> No Change	Frequency/Duration
Dates of Treatment	Date of last office visit:	Date of next scheduled office visit:
_____	_____	_____
Has patient been referred to other physicians? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," Date of Referral(s): _____		
Referral Provider Name and Phone Number: _____		Specialty: _____
Referral Provider Name and Phone Number: _____		Specialty: _____

**PHYSICIAN INFORMATION**

Provider's Name:	License Number	Social Security Number or EIN Number
Degree:	Specialty:	Fax Number:
Address: (Street, City, State & Zip Code)	Telephone Number:	
Signature:	Date Signed:	