



Renaissance[®]

DENTAL • VISION • LIFE • DISABILITY

GROUP DISABILITY CLAIM FORM PHYSICIAN STATEMENT

-Please Print or Type in Dark Ink-

INSTRUCTIONS:

This form requests information necessary for the quick and accurate administration of your patient's disability claim. If a question does not apply, or information is not available, please indicate "NA" (Not Applicable).

SEND COMPLETED FORMS TO:

- **MAIL:** PO Box 1596 Indianapolis, IN 46206
- **SECURE EMAIL:** GroupClaims@RenaissanceFamily.com
- **SECURE FAX TO:** 607-773-2276

FOR QUESTIONS CALL US AT: 844-368-6485

CLAIM NUMBER:

POLICY NUMBER:

SECTION I | PATIENT INFORMATION

Patient Name (Last, First, MI):

Date of Birth (mm/dd/yyyy):

Height:

Weight:

Blood Pressure (Last Visit):

SECTION I.I | HISTORY

A. When Did Symptoms First Appear or Accident Happen (mm/dd/yyyy):

B. Patient Is/Was Unable to Work Due To (Check One)

Injury Illness

C. Is Condition a Result of Patient's Employment:

Yes No

D. Is Condition Due to a Motor Vehicle Accident:

Yes No

E. Has Patient Ever Had a Same or Similar Condition: Yes No

If Yes, Please Describe:

F. Name and Addresses of Other Treating Physicians:

G. Have You Ever Treated Patient Prior to This: Yes No If Yes, For What and When:

SECTION I.II | DIAGNOSIS

A. Provide Diagnosis(es) and Diagnosis Code(s):

B. Subjective Symptoms:

C. Objective Findings (X-Rays, EKGs, Lab and Clinical Data:

SECTION I.III | TREATMENT

A. Date of First Visit (mm/dd/yyyy):

B. Date of Last Visit (mm/dd/yyyy):

C. Date of Next Visit (mm/dd/yyyy):

D. Frequency: Weekly Monthly Other (Please Specify):

SECTION I.IV | NATURE OF TREATMENT

Please Explain and List the Nature of Treatment (Surgery, Medications, Etc.):

Was Surgery Performed: Yes No
If Yes, Date of Surgery (mm/dd/yyyy):

Has Patient Been Hospital Confined: Yes No
From (mm/dd/yyyy):
To (mm/dd/yyyy):

SECTION I.V | EXTENT OF DISABILITY

Describe Any Restrictions (What the Patient **SHOULD NOT** Do) From (mm/dd/yyyy):

To (mm/dd/yyyy):

Describe Any Limitations (What the Patient **CANNOT** Do): From (mm/dd/yyyy):

To (mm/dd/yyyy):

Dates of Total Disability

Dates of Partial Disability

From (mm/dd/yyyy):

To (mm/dd/yyyy):

From (mm/dd/yyyy):

To (mm/dd/yyyy):

Expected Return to Work Date (mm/dd/yyyy):

How Many Days a Week Can the Patient Work:

How Many Hours Per Day Can the Patient Work:

SECTION I.VI | CARDIAC (IF APPLICABLE)

A. Functional Capacity (American Heart Association):

- Class 1:** No Limitation **Class 2:** Slight Limitation
 Class 3: Marked Limitation **Class 4:** Complete Limitation

B. Blood Pressure (Last Visit):

Systolic ____ / ____ Diastolic

SECTION I.VII | PHYSICAL IMPAIRMENT (AS DEFINED IN FEDERAL DICTIONARY OF OCCUPATIONAL TITLES)

- Class 1 - No Limitation of Functional Capacity: Capable of Heavy Work, No Restrictions (0-10%)**
 Class 2 - Medium Manual Activity (15-30%)
 Class 3 - Slight Limitation of Functional Capacity; Capable of Light Work (35-55%)
 Class 4 - Moderate Limitation of Functional Capacity; Capable of Clerical/Administrative (Sedentary) Activity (60-70%)
 Class 5 - Severe Limitation of Functional Capacity; Incapable of Minimal (Sedentary) Activity (75-100%)

Remarks:

SECTION I.VIII | MENTAL/ NERVOUS IMPAIRMENT (IF APPLICABLE)

- Class 1 - Patient Able to Function Under Stress and Able to Engage in Interpersonal Relations (No Limitations)**
 Class 2 - Patient Able to Function in Most Stress Situations and Engage in Limited Interpersonal Relations (Slight Limitations)
 Class 3 - Patient Able to Engage in Only Limited Stress Situations or Engage in Limited Interpersonal Relations (Moderate Limitations)
 Class 4 - Patient Unable to Engage in Stress Situations or Engage in Interpersonal Relations (Marked Limitation)
 Class 5 - Patient Has Significant Loss of Psychological, Physiological, Personal and Social Adjustment (Severe Limitation)

Remarks:

Do You Believe the Patient is Competent to Endorse Checks and Direct the Use of the Proceeds: Yes No

F. If You **DO NOT** Expect to be Able to Return to His/Her Occupation or Any Other Occupation, Would You Support His/Her Candidacy for Social Security Disability Benefits: Yes No

SECTION II | PHYSICIAN, PHYSICIAN ASSISTANT, NURSE PRACTITIONER STATEMENT

Print Name of Attending Physician, Physician Assistant, or Nurse Practitioner: (Last, First, MI):

Email Address:	Fax Number:		
Degree/Specialty:	Phone:		
Address (Include Apt#/Suite):	City:	State:	ZIP Code:

 X
Signature of Attending Physician, Physician Assistant, or Nurse Practitioner: _____ Date Signed (mm/dd/yyyy) _____

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ANY PERSON WHO KNOWINGLY PRESENTS A FALSE STATEMENT IN AN APPLICATION FOR INSURANCE MAY BE GUILTY OF A CRIMINAL OFFENSE AND SUBJECT TO PENALTIES UNDER STATE LAW. PLEASE SEE BELOW FOR STATE-SPECIFIC VARIATIONS OF THIS FRAUD NOTICE.

CALIFORNIA: WARNING: 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.

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