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 Medication Dosage:

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 Preformed: 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 Capable: 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 Capability; Capable of Clerical/Administrative (Sedentary) Activity (60-70%)

Class 5 - Server 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 (Server 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)*

—State Fraud Warnings on Following Pages—

LIFE AND DISABILITY STATE FRAUD WARNING STATEMENTS:

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.

FLORIDA: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

NEW YORK (EXCLUDING LIFE INSURANCE): 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.