Madison National Life

Madison National Life
Insurance Company, Inc.
P.O. Box 5008
Madison, WI 53705
608-238-2691 • 800-356-9601

ATTENDING PHYSICIAN'S STATEMENT

As your patient's disability insurer we are committed to assisting him/her in obtaining the optimum level of care so as to maximize the probability of a return to health and a successful return to productive employment. Thorough completion of this form will provide the information necessary to allow us to work closely with your patient and his/her employer to develop a plan which will promote return to health/return to work. As appropriate, we hope that you can agree to use work as a part of the medical therapy. Any recommendations you have to accomplish this goal will be carefully considered.

Name of Patient: _____ Date of Birth: _____

Address: _____ Telephone Number: _____

Social Security #: _____

Name of Employer: _____ Occupation: _____

HISTORY

1. Are you this patient's regular physician? Yes ☐ No ☐ If no, by whom was this patient referred? _____
2. Patient's Height _____ Weight _____ BP _____ Pulse (radial) _____
3. Patient's Dominant Hand Right ☐ Left ☐
4. Date symptoms first appeared _____ Date of first visit to you for this condition _____ Date of most recent visit _____ Date of next visit _____
5. Has your patient ever had the same or similar condition? Yes ☐ No ☐ If yes, indicate when and describe _____
6. Have other conditions contributed to this condition? Yes ☐ No ☐ If yes, please explain _____
7. Is condition primarily related to: Employment ☐ Illness ☐ Mental Disorder ☐ Alcohol or Drug Dependence ☐ MVA ☐ Pregnancy
   If disability is due to pregnancy, please provide the information below:
   LMP: ___/___/___ Expected date of delivery: ___/___/___ Actual date of delivery: ___/___/___ Type: ☐ C-Section ☐ Vaginal
8. Is surgery planned? Yes ☐ No ☐ If yes, indicate procedure and anticipated date
9. If patient was hospitalized, please provide dates: _____ Admitted _____ Discharged _____
10. Admitting Diagnosis: _____
11. Discharge Diagnosis: _____
12. Name of Hospital _____
    Address: _____
    STREET CITY STATE ZIP CODE

DIAGNOSIS

1. Primary Diagnosis: _____ ICD-9 Code _____
2. Secondary Diagnosis: _____ ICD-9 Code _____
3. Other diagnoses and ICD Codes related to this claim: _____
4. DSM IV Axis 1 – V (GAF): _____
5. Symptoms: _____
6. Medical findings (include x-rays, EKG's, laboratory data, any clinical findings) ***Please attach all relevant medical records to this form.***

TREATMENT PLAN

1. Planned course of treatment (please include expected duration, surgeries, therapy, etc.) _____
2. Medications prescribed (dosage, frequency and date of prescriptions: _____

Continued on reverse side

PATIENT NAME: _____ SSN: _____

TREATMENT PLAN (continued)

3. Frequency with which you see your patient: Weekly ☐ Monthly ☐ Other ☐ _____
4. Has your patient been referred to other Drs. or therapy programs (P.T., O.T., psychotherapy)? Yes ☐ No ☐ If yes, please indicate to whom and dates:

_____

_____

5. If your patient is not working now, does the treatment plan include a definitive strategy for his/her return to work? For example, have you had contact with the patient's employer regarding possible job modifications or a gradual return to work? Yes ☐ No ☐ If yes, please describe the return to work plan:

_____

_____

_____

6. If no, would you like assistance in developing a return to work plan? Yes ☐ No ☐

ASSESSMENT

1. Describe your patient's condition since onset of symptoms: Recovered ☐ Improved ☐ Unchanged ☐ Regressed ☐
2. Has your patient reached maximum medical improvement? Yes ☐ No ☐
3. When do you expect a fundamental or marked change in his/her condition? Never ☐ Condition expected to regress ☐
   Condition expected to improve ☐ State anticipated date: _____ **OR**, Unable to determine, follow up in _____ months
4. Is confinement to bed or home medically required? Yes ☐ No ☐ Please describe how your patient's condition affects his/her ability to work and also what activities the employee can do at work now – ***Please review attached job description.***

_____

_____

_____

5. **Date patient became unable to work due to this impairment? Month** _____ **Day** _____ **Year** _____
6. If physical or psychiatric limitations exist, how long do you feel limitations will last? _____

_____

7. Has your patient provided a self-report of his/her job tasks? Yes ☐ No ☐
8. Based on your knowledge of your patient's job, what reasonable work or job site modifications could the employer make to assist him/her to return to work?

_____

_____

9. Level of Functional Impairment:

a. Describe the patient's mental and cognitive limitations, if any.

b. In a work day given two breaks and a meal break, your patient can:

Lift (in pounds) ☐ 1-10 ☐ 11-20 ☐ 21-50 ☐ 51-75 ☐ 76+

Carry (in pounds) ☐ 1-10 ☐ 11-20 ☐ 21-50 ☐ 51-75 ☐ 76+

	Total									With positional change
Sit	8	7	6	5	4	3	2	1	*(hrs)*	_____
Stand	8	7	6	5	4	3	2	1	*(hrs)*	_____
Walk	8	7	6	5	4	3	2	1	*(hrs)*	_____
Alternately sit/stand	8	7	6	5	4	3	2	1	*(hrs)*	_____

Bend/stoop: ☐ Never ☐ Occasionally ☐ Frequently

10. What obstacles prevent a return to work? _____

_____

11. Would you recommend vocational rehabilitation services (assignment of a case manager to assist your patient and the employer in return to work planning, or to provide assistance in finding a new job, or in designing a retraining plan which would allow a return to work)? Yes ☐ No ☐

Comments: _____

12. Date you anticipate your patient can return to work: Part-time _____ Full-time _____
    OR, Unable to determine, due to: _____
    Follow-up in _____ months.
13. Is your patient competent to endorse checks and direct the use of the proceeds thereof? Yes ☐ No ☐

Please attach laboratory data and results of diagnostic tests as well as copies of any pertinent surgical reports, hospital admitting history, physician discharge summaries, chart notes and narrative reports.

Physician's Signature _____ Date _____

Physician's Name _____ Specialty _____

Address _____ City _____ State _____ Zip Code _____

Phone Number _____ Fax Number _____

Physician's Taxpayer ID No. _____

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EMPLOYEE'S STATEMENT OF CLAIM FOR LONG TERM DISABILITY BENEFITS

As your disability insurer we are committed to assisting you in a return to health and to productive employment. Please complete the following information thoroughly, as this will allow us to best evaluate your claim, determine your eligibility for benefits and develop a return to work plan.

I. BACKGROUND INFORMATION

Your Name (print) _____ Telephone: _____

Address _____ City _____ State _____ Zip _____

Male ☐ Female ☐ Single ☐ Married ☐ Height _____ Weight _____ Social Security Number _____

Date of birth _____ Spouse's date of birth _____ Email Address _____

Birth date of all dependent children (Dependent children are all unmarried children (1) under age 18, (2) under age 19 (if in elementary or secondary school and (3) disabled children regardless of age if disability began before age 22)

_____

_____

Your Employer's Name _____

Occupation/Job Title _____

Basic Annual Salary in effect immediately prior to injury/illness $_____

Please indicate the extent of your formal education (*circle one*)

High School: 1 2 3 4 5 6 7 8 9 10 11 12

College: 1 2 3 4 Masters _____ Ph.D. _____

Trade School: _____

Briefly describe your past work experience for the last 20 years (*begin with your most recent job*).

Job Title	Duties	Years Worked
(a)		
(b)		
(c)		
(d)		

II. CLAIM INFORMATION

1. Is your claim related to an injury? Yes ☐ No ☐ Date and Time of Injury _____
   Describe how and where injury occurred: _____

   _____

   _____

2. Is your claim related to your occupation? Yes ☐ No ☐ If yes, have you filed a Worker's Compensation claim? Yes ☐ No ☐
   If you are receiving Workers' Compensation benefits, have you been contacted by the Workers' Compensation carrier regarding vocational rehabilitation services? Yes ☐ No ☐ If yes, what is the name, address and phone number of the counselor handling your case? _____

   _____

3. Is your claim related to an illness? Yes ☐ No ☐ Date Symptoms first appeared _____
   Describe the nature of your illness: _____

   _____

4. Date you were first disabled by your illness or injury: _____
5. Have you returned to work yet? Yes ☐ Part-time date _____ Full-time date _____ No ☐ Date last worked _____
6. When do you plan to return to your job either on a full-time or part-time basis? Please explain in detail. _____

   _____

7. Please describe the primary tasks of your job/occupation: _____

   _____

   _____

8. Has your doctor provided work restrictions? Yes ☐ No ☐ If so, please describe. _____

   _____

9. Can you return to your job or another job with your current employer, if accommodations were made? If so, please describe your accommodation needs.

   _____

Continued on reverse side

NAME _____ SOCIAL SECURITY NUMBER _____

II. CLAIM INFORMATION - continued

10. Are there any concerns you have about returning to work? If so, please describe. _____

11. Have you tried any type of work since you left your regular job (either for this employer, another employer or through self-employment) since your disability began? Yes ☐ No ☐ If yes, provide name and address of employer, type of work, when employment began and number of hours worked per week. _____

III. MEDICAL INFORMATION

1. Please provide us with a brief description of your condition(s). Describe any physical and/or psychiatric/psychological limitations related to your return to work: _____

2. Physicians: Please list all Attending Physicians and Specialists to whom you have been referred for this condition(s):

Physician's Name/Specialty	Address	Phone Number	Dates of Treatment

3. Have you ever had the same or similar condition in the past? Yes ☐ No ☐ If yes, give name and address of hospital and doctor.

Hospital

Name	Street Address	City	State	Zip	Phone

Doctor

Name	Street Address	City	State	Zip	Phone

ARE YOU ENTITLED TO BENEFITS FROM ANY OF THE FOLLOWING FOR THIS DISABILITY? YOU MUST FILE FOR ANY BENEFITS TO WHICH YOU ARE ENTITLED.

SALARY CONTINUATION/COMMISSION	YES ☐ NO ☐	SOCIAL SECURITY DISABILITY OR RETIREMENT	YES ☐ NO ☐	UNEMPLOYMENT BENEFITS	YES ☐ NO ☐
VACATION/BONUS PAY	YES ☐ NO ☐	ANY OTHER GOVERNMENT AGENCY (SPECIFY)	YES ☐ NO ☐	RETIREMENT BENEFITS	YES ☐ NO ☐
AUTOMOBILE NO-FAULT	YES ☐ NO ☐	PROFESSIONAL RETIREMENT PLAN	YES ☐ NO ☐	OTHER DISABILITY INCOME	YES ☐ NO ☐
WORKERS' COMPENSATION	YES ☐ NO ☐	SHORT TERM DISABILITY	YES ☐ NO ☐	DISABILITY RETIREMENT	YES ☐ NO ☐

FOR ANY "YES" ANSWERS, GIVE THE POLICY OR PLAN NUMBER, NAME AND ADDRESS OF THE COMPANY OR ORGANIZATION PROVIDING BENEFITS AND THE AMOUNT

POLICY OR PLAN NUMBER	NAME & ADDRESS	AMOUNT OF PAYMENT	WEEK ☐ MONTH ☐
POLICY OR PLAN NUMBER	NAME & ADDRESS	AMOUNT OF PAYMENT	WEEK ☐ MONTH ☐

* Please attach a copy of any Social Security Award Certificate, Social Security Disability Denial Notice or other correspondence explaining a decision received from the Social Security Administration.

If your employer pays any portion of the premium or premiums are withheld from your pay on a pre-tax basis, you may elect to have Federal Income Tax withheld from each payment. Please note, the minimum monthly withholding is $_____ Federal Tax withholding is not mandatory. Do you want amounts withheld for Federal Tax purposes? Yes ☐ No ☐ If yes, we will send you a form to complete.

IV. AUTHORIZATION

To all physicians and other medical professionals, hospitals and other medical care institutions and to insurers, medical or hospital service and prepaid health plans, employers and group policyholders, contract holders or benefit plan administrator: You are authorized to provide Madison National Life Insurance Company, Inc., its affiliates and reinsurers, and any agent, benefit plan administrator, consumer reporting agency or independent claim administrator acting on behalf of Madison National Life Insurance Company, Inc. with information concerning medical care, advice, treatment or supplies provided for the patient named below. I also authorize my employer, group policyholder, or benefit plan administrator to provide Madison National Life Insurance Company, Inc. with financial or employment-related information. This information will be used for evaluating a claim for benefits. I understand that the authorization is for the term of coverage of the policy or contract under which a claim for disability benefits has been submitted, and that it is valid for the duration of the claim. I also understand that I or my authorized representative may receive a copy of this authorization upon request. A copy of this authorization shall have the same authority as the original.

Any person who knowingly and with intent to defraud any insurance company or other person files a 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 subject such person to criminal and civil penalties.

Signature _____ Date _____

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LONG TERM DISABILITY CLAIM EMPLOYER'S STATEMENT

As your disability insurance provider, we are committed to assisting you to return your employee to productive employment. Please complete the following information thoroughly, as this will allow us to accurately evaluate this claim, assist you to develop an action plan to allow a successful return to work for your employee and determine what services may be necessary to accomplish this.

Employee's Name:_____ Social Security#:_____ Date of Birth:_____

Address:_____
STREET CITY STATE ZIP CODE

Telephone number:_____

HISTORY

1. Employee's Date of Hire_____ Date employee became insured under this plan ____/____/____.
2. What was the employee's permanent job on his or her last day of work?

   _____
3. How long had the employee been in this job? _____
4. Last date employee actually worked _____. On that day did the employee work a full day? Yes ☐ No ☐
   If "No", how many hours were worked? _____
5. Why did your employee stop working? _____

   _____

   _____
6. Were there any changes to your employee's job responsibilities due to the disabling condition before the employee became fully disabled?
   Yes ☐ No ☐ If yes, what were the changes and when were they made? _____

   _____
7. What is your employee's regularly scheduled work week? _____hours per week _____hours per day
8. What was your employee's Basic Monthly Salary immediately prior to cessation of work because of disability? _____
9. Has your employee returned to work? Yes ☐ No ☐
   If yes, Part-time Date_____ Full-time Date_____ With restrictions_____ Full capacity_____.
10. Name, address, and telephone number of your medical insurance carrier:
    Carrier's Name:_____
    Address:_____
    STREET CITY STATE ZIP CODE
    Telephone Number:_____

BENEFITS

1. Is the employee's disabling condition work-related? Yes ☐ No ☐ Comments: _____
2. Has a claim been filed with Workers' Compensation? Yes ☐ No ☐ Currently Disputed ☐ If yes, send initial report of injury and award notice.
3. Name, address, and telephone number of your worker's compensation carrier:
   Carrier's Name:_____
   Address:_____
   STREET CITY STATE ZIP CODE
   Telephone Number:_____
4. Does employee contribute towards the cost of this LTD insurance? Yes ☐ No ☐
   If "Yes", ☐ Pre-tax ☐ Post-tax If "Post-tax", _____% premium dollars paid by employer, _____% paid by employee.

(Note: If employee paid disability premium is pre-tax, we will deduct FICA tax as if the employer was paying 100% of the disability premium.)

Continued on reverse side

BENEFITS (continued)

5. If a contract day employee, what are the number of contract days for the school year in which disability began _____ Please attach a copy of the school calendar for all years involved in disability period.

6. Has the employee received, or will he/she receive Salary Continuance, Sabbatical Pay, or Sick Leave since the time last worked? Yes ☐ No ☐
If yes, amount $_____ week ☐ month ☐ Payable from _____ through _____

7. To the best of your knowledge, is your employee receiving, or entitled to receive benefits from any of the following as a result of this disability:

_____ Social Security

_____ Other Government Agency

_____ Teachers' or Public Employees' Retirement System

_____ Statutory Disability Income, e.g. Workers' Compensation

_____ Any Other Disability or Retirement Plan (employer-sponsored or not)

For any "yes" answer other than Social Security, please provide the following information:

Policy/Plan Number _____ Name and Address of carrier or administrator _____

RETURN TO WORK CONSIDERATIONS (complete if employee has not yet returned to work)

1. Does your company/organization have a return-to-work policy for disabled employees? Yes ☐ No ☐

2. Do you, or does someone from your company/organization, maintain contact with your employee? Yes ☐ No ☐ Frequency? _____

3. Can you provide transitional job duties for your employee to allow a gradual return to work? Yes ☐ No ☐

4. Has this information been communicated to your employee's physician? Yes ☐ No ☐

5. Have you discussed a return to work with your employee? Yes ☐ No ☐ What is the anticipated return to work date? _____

6. What is the name, telephone number and title of the supervisor we should contact if we identify a rehabilitation or return-to-work option?

_____
NAME TITLE TELEPHONE NUMBER

7. Would you like a Vocational Rehabilitation Case Manager to assist you in the return to work process? Yes ☐ No ☐

8. Do you have any other comments which might help us better manage this claim? _____

_____

_____

_____

_____

_____

Employer's Name_____Group/Policy #: _____

Mailing Address:_____
STREET CITY STATE ZIP CODE

Name and Title of individual completing this form (please print) _____

Telephone number:_____ Fax Number: _____

Signature_____ Date _____

PLEASE ATTACH A JOB DESCRIPTION OUTLINING THE JOB DUTIES AND PHYSICAL DEMANDS TO THIS APPLICANT'S OCCUPATION