ATTENDING PHYSICIAN'S STATEMENT — PROGRESS REPORT

(The patient is responsible for the completion of this form without expense to the Company. Please fully answer each question. Attach additional sheets if necessary.)

GROUP POLICY NUMBER: G-11628   PATIENT'S SOCIAL SECURITY NO OR ID: ______________________

1. PATIENT'S NAME: ______________________________ DATE OF BIRTH: ______ /______ /______
   (First) (Middle) (Last) *(Month) (Day) (Year)*

2. CURRENT MEDICAL CONDITION(s):
   PRIMARY DIAGNOSIS: ______________________ ICD-10-CM CODE: __________
   SECONDARY DIAGNOSIS: ______________________ ICD-10-CM CODE: __________

3. DATES YOU HAVE PROVIDED TREATMENT TO THE PATIENT SINCE YOUR LAST REPORT TO US:
   ____

6. CURRENT OBJECTIVE FINDINGS *(Include x-ray, lab results and clinical findings. If pregnancy, also give LMP and EDC):*
   ____

5. HAS PATIENT BEEN HOSPITALIZED SINCE THE DATE OF YOUR LAST REPORT TO US? YES ❑ NO ❑
   *(If "YES", provide hospital name and dates of confinement):*______________________
   ____

4. NATURE OF TREATMENT CURRENTLY BEING PROVIDED OR PLANNED *(include surgery and medications prescribed if applicable):*
   ____

7. HAVE YOU REFERRED THE PATIENT TO ANOTHER PHYSICIAN OR PRACTITIONER? YES ❑ NO ❑
   (If "YES", provide the name and address of all applicable physicians or practitioners): ______________________
   ____

8. IN YOUR OPINION, IS THE PATIENT ABLE TO WORK AT THIS TIME? YES ❑ NO ❑
   IF "NO" WHEN DO YOU EXPECT THAT THE PATIENT WILL BE ABLE TO PERFORM SOME WORK? ______/______/______
   (Month) (Day) (Year)

9. IS THERE ANY TYPE OF JOB MODIFICATION OR ACCOMMODATION THAT WOULD ENABLE THE PATIENT TO WORK AT THIS TIME?
   YES ❑ NO ❑ *(If "YES", please describe):* ______________________
   ____

10. BASED ON YOUR OBJECTIVE FINDINGS AND MEDICAL OPINION:
   a.) THE PATIENT WAS UNABLE TO WORK FROM: ______/______/______ *(Month) (Day) (Year)* THROUGH: ______/______/______ *(Month) (Day) (Year)*
   b.) THE PATIENT WAS UNABLE TO PERFORM SOME WORK FROM: ______/______/______ *(Month) (Day) (Year)* THROUGH: ______/______/______ *(Month) (Day) (Year)*

11. LIST ALL CURRENT RESTRICTIONS AND LIMITATIONS YOU HAVE PLACED ON THE PATIENT'S WORK AND PERSONAL ACTIVITIES DUE TO THEIR MEDICAL CONDITION *(If none, indicate "NONE"):*
   ____
   ____

12. HAS THE PATIENT BEEN RELEASED FROM YOUR CARE? YES ❑ NO ❑

   IF 'YES", DATE THEY WERE RELEASED FROM YOUR CARE ______/______/______ *(Month) (Day) (Year)*

   IF "NO", DATE OF NEXT SCHEDULED TREATMENT OR EVALUATION: ______/______/______ *(Month) (Day) (Year)*

New York Residents: 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.

ATTENDING PHYSICIAN'S DECLARATION AND SIGNATURE

I declare that the answers on this statement are complete and true to the best of my knowledge and belief. I understand that periodic updates (including providing copies of medical records when requested) will be required in the event of a continuing claim.

______________________ PROVIDER'S NAME (PLEASE PRINT)   ______________ SPECIALTY   ______________ TELEPHONE NUMBER

______________________ STREET ADDRESS CITY STATE ZIP   ______________ PROVIDER'S SIGNATURE   ______________ DATE SIGNED

MAIL TO:

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