1 *Professional Insurance Co*
PO Box 85656, Lincoln, NE 68501
1-800-289-1122

Supplementary Statement of Disability

Must Be Completed in Full at No Expense to Professional Insurance Company

Employee Statement

Claimant's Full Name (Please Print) Policy number Claim number

1. Have you returned to any work since you were disabled? No Yes Date _____ Part-time Full-time

2. Do you expect to return to work in the near future? No Yes Approximate date _____ Part-time Full-time

3. Have there been any changes in your condition in the past year?
   Remains the same Has worsened Has improved

4. Have there been any changes in your lifestyle? No Yes If yes, please explain_____
   _____
   Are you living: At home In an assisted living facility (Address)_____
   In a Convalescent facility (Address) _____

5. Activities of daily living.
   Are you able to Ambulate without assistance Leave your home Drive

6. Are you currently participating in any
   Part-time work Volunteer work Study program Therapy
   If "yes" to any of the above please explain _____
   _____
   _____

7. Are you now eligible for, have you applied for, or are you now receiving income from:

	Yes	No	Amount of income	Period (Wk, Bi-Wk or Mo)	Date Application Filed	Date Income Began	Date Income Ended
Primary Social Security			$_____	per _____	___/___/___	___/___/___	___/___/___
Dependent Social Security Child(ren) Spouse			$_____	per _____	___/___/___	___/___/___	___/___/___
Workers Compensation			$_____	per _____	___/___/___	___/___/___	___/___/___
Company Pension			$_____	per _____	___/___/___	___/___/___	___/___/___
Unemployment Compensation			$_____	per _____	___/___/___	___/___/___	___/___/___
State Cash Sickness Plan (SDI, TDB, DBL, TDI)			$_____	per _____	___/___/___	___/___/___	___/___/___
Other disability income benefits			$_____	per _____	___/___/___	___/___/___	___/___/___

Description _____

State law, in some states, requires the following statement: 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 (in Oregon "may be guilty of insurance fraud") commits a fraudulent insurance act, which (in Oregon "may be subject to prosecution") is a crime and subjects such person to criminal and civil penalties. **This notice does not apply to Virginia.**

AUTHORIZATION TO OBTAIN AND REDISCLOSE INFORMATION

I hereby authorize any hospital, physician, pharmacy or other person, or any health care provider, Insurance Company, Plan Administrator, any Government Agency, Social Security Administration, any information gathering services such as MIB, Inc, or HCI to disclose or furnish to Professional Insurance Company or its representatives, any and all information with respect to any injury or illness including mental illness, drug/alcohol abuse, HIV-related, AIDS or AIDS related information to the extent permitted by law, medical history, consultations, prescriptions, treatments or benefits and copies of all applicable records that may be requested. I also authorize my employer to disclose all information needed to evaluate my claim. A photographic copy of this authorization shall be considered as effective and as valid as the original. This authorization is valid for the duration of the claim up to 24 months from the date it was signed. You have the right to revoke this authorization at any time by writing to Professional Insurance Company at the address listed at the top of this form*. Revocation of this authorization will not affect the rights of anyone who acted in reasonable reliance on the authorization before receiving notice of its revocation. Failure to sign this authorization may impair our ability to process a claim and may be the basis for denying a claim for benefits.

Date **Claimant's Signature** **Phone Number**

( )

Address (No., Street, City, State, Zip Code)

ATTENDING PHYSICIAN'S SUPPLEMENTAL STATEMENT

ACCIDENT OR SICKNESS

PLEASE ANSWER ALL QUESTIONS

Policy number_____

Claim number_____

Patient Name _____

1. DIAGNOSIS (including any complications) _____
   _____ICD-9 Code _____
   (a) Objective findings (including current MRI, x-rays, EKG, laboratory data and any clinical findings)._____
   _____
   (b) Subjective symptoms _____
   (c) Has patient been hospital confined? Yes No
   If yes, name/address of hospital _____
   Confined from _____ through _____

2. DATES OF TREATMENT
   (a) Date of last visit Mo. _____ Day _____ Year _____
   (b) Frequency Weekly Monthly Other (Specify) _____

3. NATURE OF TREATMENT (Including surgery and medications prescribed, if any).

4. PROGRESS
   (a) Is patient Totally Disabled? Yes No
   (b) Is patient Partially Disabled? Yes No
   (c) When is patient expected to return to work? Mo. _____ Day _____ Year _____
   (d) Has patient reached Maximum Medical Improvement? Yes No
   If no, when do you expect a fundamental change? Mo. _____ Day _____ Year _____
   (e) Is patient a suitable candidate for further rehabilitation services? Yes No
   If yes, circle applicable services: Medical Psychological Vocational

5. 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 _____/_____

6. FUNCTIONAL LIMITATIONS – ABILITIES

Indicate frequency per day the listed activity can be performed.
(n – never, o – occasional, f – frequent, c – constant)

LIFTING
_____1-10 lbs.
_____11-25 lbs.
_____26-50 lbs.
_____51-100 lbs.
_____over 100 lbs

CARRYING
_____1-10 lbs.
_____11-25 lbs.
_____26-50 lbs.
_____51-100 lbs.
_____over 100 lbs

Indicate longest single time duration each activity can be performed.

_____Sitting _____Kneeling _____ R Finger Dexterity
_____Total time on feet _____ L
_____Standing _____Inside _____ R Below Shoulders
_____Walking _____ L
_____Bending _____Outside _____ R Above Shoulders
_____Squatting _____Working with _____ L
_____Stooping _____Other (explain)_____
_____

Doctor: Please describe fully how patient's symptoms/limitations affect ability to work, e.g. how are work schedule and duties restricted and why?

For Maternity Claims (Describe complications, if any) _____
Date of Delivery _____ Type of Delivery Normal Cesarean

7. PSYCHIATRIC IMPAIRMENT (if applicable)
   (a) Please define "stress" as it applies to this claimant. _____
   _____
   (b) What stress and problems in interpersonal relations has claimant had on job?
   Class 1 – Patient is able to function under stress and engage in interpersonal relations (no limitations)
   Class 2 – Patient is able to function in most stress situations and engage in most interpersonal relations (slight limitations)
   Class 3 – Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations (moderate limitations)
   Class 4 – Patient is unable to engage in stress situations or engage in interpersonal relations (marked limitations)
   Class 5 – Patient has significant loss of psychological, personal and social adjustment (severe limitations)

8. Doctor: Please include copies of office notes for the period of treatment, test results, available discharge summaries and any consulting physician reports.

Name of Attending Physician (Please Print) Degree Telephone Fax

Street Address City or Town State or Province Zip Code

Signature Date Taxpayer ID Number (EIN)