Attending physician statement of disability

Blue Shield of California Life & Health Insurance Company

4203 Town Center Blvd., El Dorado Hills, CA 95762 (888) 800-2742

The insured is responsible for completion of this form without expense to the Company.

All applicable questions must be answered on all pages of the form

Name	Date of birth	Group no.	SSN
Present address (Street, city, state, ZIP)			
Telephone numbers ( ) ( )		Gender ☐ F ☐ M	Is disability work related? ☐ Yes ☐ No
Signature		Date	

1 Disability (including complications)

2 Any other diagnosis/conditions

3 Nature of treatment (including medications prescribed and surgery)

Date of last examination	Type of treatment rendered
Frequency of treatment: ☐ Weekly ☐ Monthly	☐ Other (specify)

4 Progress

Insured is: ☐ House confined ☐ Hospital confined ☐ Bed confined ☐ Ambulatory

☐ Acute ☐ Skilled nursing Confined from: _____ through _____

What restrictions, if any?	

☐ Recovered ☐ Improved ☐ Unchanged ☐ Retrogressed

Explanation of boxes checked:	

5 Cardiac (if applicable)

A **Functional capacity** (American Heart Association)

☐ Class 1 (no limitation) ☐ Class 2 (slight limitation)
☐ Class 3 (moderate limitation) ☐ Class 4 (complete limitation)

B **Blood pressure** (last visit):

Systolic _____ Diastolic _____

6 Physical impairment (as defined in Federal Dictionary of Occupational Titles)

☐ Class 1: No limitations 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 (25-55%)
☐ 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:

7 Mental/nervous impairment (if applicable)

A Please define "stress" as it applies to this claimant.

B What stress and problems in interpersonal relations has the claimant had on the 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, physiological, personal and social adjustment (severe limitations)

Remarks:

Do you believe the patient is competent to endorse checks and direct the use of the proceeds thereof? ☐ Yes ☐ No

8 Rehabilitation

A Is the patient a suitable candidate for further rehabilitative services (i.e., cardiopulmonary program, speech therapy, etc.)? ☐ Yes ☐ No

B Can present job be modified to allow for handling with impairment? ☐ Yes ☐ No

C Would vocational counseling and/or retraining be recommended? ☐ Yes ☐ No

D

When could trial employment commence?	Patient's job	Any other work
	Month, day, year ☐ Full-time ☐ Part-time	Month, day, year ☐ Full-time ☐ Part-time

9	Prognosis		
A	Is patient now total disabled from performing his/her regular job? ☐ Yes ☐ No		
B	Is patient not totally disabled from performing all other types of work? ☐ Yes ☐ No		
C	Do you expect any significant improvement in the future? ☐ Yes ☐ No		
	If yes, when will the patient recover sufficiently to perform the duties of:	Patient's job ☐ 1 month ☐ 1-3 months ☐ 3-6 months ☐ Never _____ /_____ /_____ Month, day, year	Any other work ☐ 1 month ☐ 1-3 months ☐ 3-6 months ☐ Never _____ /_____ /_____ Month, day, year
	If no, please explain:		
	If the patient is only partially disable, please give the dates of partial disability:		From_____ to _____

Name (please print)	Address (Street, City, State, and ZIP Code)	
Telephone No. ( )	Signature—*The above statements are true and complete to the best of my knowledge and belief.*	Date

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.