KANSAS CITY LIFE

GROUP BENEFITS

KANSAS CITY LIFE INSURANCE COMPANY

APPLICATION FOR LONG TERM DISABILITY INCOME BENEFITS

This application package is divided into four sections, as follows:

Section 1	**Employer's Statement** – to be completed by the employer's authorized representative.
Sub-section 1c.	**Information for Group Life Premium Waiver Benefits** – to be completed by the employer's authorized representative if the employer also has a Group Life Insurance policy with Kansas City Life Insurance Company that includes a Premium Waiver benefit. Be sure to provide any necessary attachments (see Section K).
Section 2	**Employee's Statement** – to be completed by the employee who is applying for Long Term Disability benefits.
Section 3	**Authorization to Obtain Information** – to be signed by the employee.
Section 4	**Attending Physician's Statement** – to be completed by the physician who is treating the employee.

PLEASE SEE THAT ALL SECTIONS ARE FULLY COMPLETED AND SIGNED. FORWARD THE COMPLETED APPLICATION TO:

DISABILITY CLAIM OFFICE
300 Southborough Dr., Ste. 200
South Portland, ME 04106-6914

Toll free: 888-305-0590
Fax: 207-766-3448
Email: *Claims@DisabilityRMS.com*

KANSAS CITY LIFE
GROUP BENEFITS

APPLICATION FOR LONG TERM DISABILITY INCOME BENEFITS **Section 1**

KANSAS CITY LIFE INSURANCE COMPANY **Employer's Statement**

To Be Completed by the Employer

This claim is for *(employee's name)*	Social Security number	Date of birth

Employee's address *(street, city, state, ZIP)*

A. Information About the Employer

Company's name	Group policy number
Address *(street, city, state, ZIP)*	Phone number
Name and address of division where employee works *(if different from above)*	Fax number

B. Information About the Employee

Date employee was hired _____ Date employee became insured under this plan	What was the employee's regularly scheduled work week? Hours per week _____ Scheduled workdays M – F _____ Other _____

IS EMPLOYEE ENROLLED IN KANSAS CITY LIFE LONG TERM DISABILITY PLAN ? ☐ **Yes** ☐ **No**

IF "YES," EFFECTIVE DATE _____

Was the employee's LTD insurance issued on the basis of a personal health statement? ☐ Yes ☐ No If "Yes," attach copy.

Was the employee insured under your prior LTD policy? ☐ Yes ☐ No

If "Yes," please provide the inclusive date of coverage. From _____ through_____

Has the employee been terminated? ☐ Yes ☐ No If "Yes," date: _____

Reason:

_____

Was the employee on qualified family leave when disability began? ☐ Yes ☐ No

Did STD and LTD insurance continue while on family leave? ☐ Yes ☐ No

Date leave of absence started under Family Leave Act _____

C. Information for Group Life Premium Waiver Benefits

Does the employee also have group life insurance coverage with **Kansas City Life Insurance Company**? ☐ Yes ☐ No

If "Yes," provide the following information:

Basic Amount $ _____

Supplemental amount $ _____

Effective date of group life insurance coverage _____

D. Information Needed for Withholding and Reporting Taxes

Percentage of employee/employer contribution to premium for this disability plan

(as of policy year of disability)

Employee ☐ 100% ☐ Other _____ Is employee contribution: ☐ Pre-tax deduction ☐ After-tax deduction

Employer ☐ 100% ☐ Other _____

E. Information About the Claim

Were there any changes to the employee's job responsibilities due to the disabling condition before the employee became totally disabled?

☐ Yes ☐ No If "Yes," what were the changes, and when were they made?

What was the employee's permanent job on his or her last day at work? ***(Please attach a copy of the employee's job description.)***	How long had the employee been in this job?

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Last day employee actually worked	On that day, did the employee work a full day? ☐ Yes ☐ No If "No," how many hours were worked? _____
Why did employee stop working?	Is the employee's condition work related? ☐ Yes ☐ No
Has a claim been filed with workers' compensation? ☐ Yes ☐ No If "Yes," send initial report of illness or injury or award notice.	Date employee is expected/did return to work? _____ Full time? ☐ Yes ☐ No

Name and address of your compensation carrier _____

F. Information About Your Pension Plan *(Do not complete for maternity claim.)*

Do you have a pension plan? ☐ Yes ☐ No	If "Yes," what type? *(Check as many as applicable.)*	☐ Defined benefit ☐ Defined contribution	☐ 401(k) ☐ Profit sharing	☐ Other *(specify)* _____

Is the employee eligible for your pension plan? ☐ Yes ☐ No If "No," why?	If eligible, does the employee participate? ☐ Yes ☐ No If "No," why?

If the employee is participating, when is he or she eligible for benefits under the plan? *(month/day/year)* _____

At what point does the employee qualify for a full pension? _____

Is there a disability retirement option available to this employee? ☐ Yes ☐ No

G. Information About Your Rehire or Return-to-Work Policies

Does your company have a rehire or return-to-work policy for disabled employees? ☐ Yes ☐ No

What is the name and title of the manager we should contact if we identify a rehabilitation or return-to-work option?

H. Information About the Employee's Salary

Please indicate how the employee is paid. *(Check all that apply.)*

☐ Hourly ☐ Salaried ☐ Other _____

☐ Includes commissions?

☐ Includes bonuses?

Basic salary or wage immediately prior to cessation of work because of disability (exclude bonuses, overtime, pay, etc.)

$_____ ☐ Monthly ☐ Weekly ☐ Annually ☐ Hourly – number of hours/week _____

Is this employee eligible for salary continuation?

☐ Yes ☐ No If "Yes," what is the weekly amount? $ _____ When do benefits begin? _____ End? _____

Will the employee file for Short Term or State Disability benefits?

☐ Yes ☐ No If "Yes," what is the weekly amount? $ _____ When do benefits begin? _____ End? _____

List any other sources of income to which the employee is entitled as a result of this disability:

I. Information About the Physical Aspects of the Employee's Job

Can the job be performed by alternating sitting and standing? ☐ Yes ☐ No

What are the major tasks requiring the use of one or both hands? Indicate the percentage of the employee's workday that is spent on each of these tasks.

_____ _____ %

_____ _____ %

_____ _____ %

_____ _____ %

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Check the items below that relate to the employee's job and complete the information requested. Use these definitions for the frequency of occurrence.

Not Applicable (N/A) means the person does not perform this activity.
Occasionally means the person does the activity up to 33% of the time.
Frequently means the person does the activity 34% to 66% of the time.
Continuously means the person does the activity 67% to 100% of the time.

		Frequency of Occurrence		
Activity	**N/A**	**Occasionally**	**Frequently**	**Continuously**
☐ Standing	☐	☐	☐	☐
☐ Walking	☐	☐	☐	☐
☐ Sitting	☐	☐	☐	☐
☐ Balancing	☐	☐	☐	☐
☐ Stooping	☐	☐	☐	☐
☐ Kneeling	☐	☐	☐	☐
☐ Crouching	☐	☐	☐	☐
☐ Crawling	☐	☐	☐	☐
☐ Reaching/working overhead	☐	☐	☐	☐
☐ Keyboard use/repetitive hand motion	☐	☐	☐	☐
☐ Climbing	☐	☐	☐	☐

Activity	**Description**	**Frequency**	**Weight**
☐ Pushing	_____	_____	_____ lbs.
☐ Pulling	_____	_____	_____ lbs.
☐ Lifting	_____	_____	_____ lbs.
☐ Carrying	_____	_____	_____ lbs.

J. Information About the Job as it Relates to the Disability

Can the job be modified to accommodate the disability either temporarily or permanently? ☐ Yes ☐ No If "Yes," explain.

Is it possible to offer the employee assistance in doing the job *(e.g., through the use of technology or personal assistance)*? ☐ Yes ☐ No If "Yes," explain.

K. Required Attachments and Signature

Please attach a copy of the employee's job description.

If the employee contributes to the premiums for LTD or Group Life Insurance coverage, attach a copy of the enrollment form and/or copies of the last two Flexible Benefits Election forms.
If salary is based on a W-2, K-1, 1099, or a similar document, attach a copy of the document.
If you have medical information from the employee's file relating to this disability, please attach copies.
If a Workers' Compensation claim is filed, send initial report of injury or illness and award notice.
Name of person completing this form (if this claim is approved for disability benefits, the benefit check will be sent to the employee with a copy to you).

_____ Name *(Please print or type.)*

_____ Title

_____ Signature

_____ Date

_____ Phone number

_____ Fax number

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KANSAS CITY LIFE
GROUP BENEFITS

APPLICATION FOR LONG TERM DISABILITY INCOME BENEFITS **Section 2**

KANSAS CITY LIFE INSURANCE COMPANY **Employee's Statement**

To Be Completed by the Employee (BE SURE TO ANSWER ALL QUESTIONS – FAILURE TO DO SO MAY DELAY YOUR CLAIM)

A. Information About You

Last name	First	Middle initial	Social Security number

Address	City	State/province	ZIP

Phone number	Height	☐ Male ☐ Single ☐ Widowed
Date of birth *(month/day/year)*	Weight	☐ Female ☐ Married ☐ Divorced
Your employer *(include division, if applicable)*		Occupation

When your disability began, did you have more than one employer? ☐ Yes ☐ No If "Yes," please provide the name, address and phone number of that employer, and indicate the dates when you worked.

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)		

Now, or at some time in the future, would you be interested in seeking rehabilitation to some other kind of work? ☐ Yes ☐ No

Have you contacted your state department of vocational rehabilitation? ☐ Yes ☐ No If "Yes," please include the name, address and telephone number of your counselor.

B. Information About your Family *(required to determine your eligibility for Social Security benefits)*

Spouse's name *(last, first)*

Spouse's Social Security number	Date of birth *(month/day/year)*	Is your spouse employed? ☐ Yes ☐ No	Retired? ☐ Yes ☐ No

Do you have any children under age 19? ☐ Yes ☐ No

If "Yes," name and date of birth of each child

Do you have any children with disabilities *(regardless of age)*? ☐ Yes ☐ No

If "Yes," name and date of birth of each child

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C. Information About the Condition Causing Your Disability

For illness, answer the following questions:

What were your first symptoms?

When did you first notice them?	Have you had this illness before? ☐ Yes ☐ No If "Yes," when?

For an injury, answer the following questions:

When *(i.e., date/time)*, where and how did the injury occur?

For illness, injury or pregnancy, answer the following questions:

Date you were first treated by a physician *(month/day/year)*	Name of physician _____ Address of physician _____ Phone number _____

Before you stopped working, did your condition require you to change your job, or the way you did your job? ☐ Yes ☐ No If "Yes," explain.

What aspect of your condition made you unable to work?

Is your condition related to your occupation? ☐ Yes ☐ No If "Yes," explain.

Have you filed, or do you intend to file a workers' compensation claim? ☐ Yes ☐ No If "Yes," explain.

D. Information About the Disability

Last day you worked before the disability *(month/day/year)*	Did you work a full day? ☐ Yes ☐ No If "No," explain.	Date you were first unable to work *(month/day/year)*

Since that date, have you done any work? ☐ Yes ☐ No If "Yes," please indicate dates worked, name of employer and amount earned.	If you have not returned to work, do you expect to? ☐ Yes Part time *(date)* _____ Full time *(date)* _____ ☐ No

FOR PREGNANCY DISABILITY ONLY:

Are there any present complications or anticipated difficulties in connection with:

a) Pregnancy ☐ Yes ☐ No Date of last menstrual period _____ Expected date of delivery _____

b) Delivery ☐ Yes ☐ No Actual date of delivery _____ ☐ Vaginal ☐ C-section

c) Postpartum ☐ Yes ☐ No

If "Yes" to any of these, please specify in detail

E. Information about physicians and hospitals

First medical attention for the current disability was given by *(complete below)*

Doctor's name	Phone number Fax number	Specialty
Address *(street, city, state, ZIP)*		Dates seen _____ **to** _____

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List all physicians and hospitals you have seen for this condition *(attach separate sheet, if needed)*

Doctor's name	Phone number Fax number	Specialty
Address *(street, city, state, ZIP)*		Dates seen _____ **to** _____
Hospital		
Address *(street, city, state, ZIP)*		Dates of confinement _____ **to** _____

Have you consulted any other physicians or been hospitalized in the past three years? ☐ Yes ☐ No

If "Yes," complete the following concerning your past treatment *(attach separate sheet, if needed)*

Doctor's name	Phone number Fax number	Specialty
Address *(street, city, state, ZIP)*		Dates seen _____ **to** _____
Hospital		
Address *(street, city, state, ZIP)*		Dates of confinement _____ **to** _____

F. Other Income

Other income benefits you have received/are receiving, or are eligible to receive during your disability *(complete the information requested).*

Source of Income	Amount (week /month)	Date Claim was Filed	Date Payments Began	Date Payments Ended
Social Security/retirement	$_____/_____			
Social Security/disability	$_____/_____			
Sick pay or salary continuation	$_____/_____			
Income from work	$_____/_____			
Workers' compensation	$_____/_____			
State disability	$_____/_____			
Pension/retirement	$_____/_____			
Pension/disability	$_____/_____			
Short term disability	$_____/_____			
Unemployment	$_____/_____			
No-fault insurance	$_____/_____			
Other *(include Individual or Group Benefits)*	$_____/_____			

G. Information About Tax Withholding

Federal law requires us to withhold federal income tax from your check ***if you request us to do so***. We are also required to send a report to your employer at the end of each calendar year showing your name, total amount of benefits paid to you, total amount withheld, if any, and your social security number. If you want us to withhold tax, please indicate on the line below the dollar amount to be withheld per benefit check. Whole dollars only (minimum is $88.00 per month): $_____.00.

H. Signature

With the exception of any source(s) of income reported above in Section F of this form, I certify by my signature that I have not and am not eligible to receive any source of income, except for my **Kansas City Life Insurance Company** Disability Income. Further, I understand that should I receive income of any kind or perform work of any kind during any period **Kansas City Life Insurance Company** has approved my disability claim, I must report all details to **Kansas City Life Insurance Company**, immediately.

If I receive disability benefits greater than those which should have been paid, I understand that I will be required to provide a lump sum repayment to the insurance company. The insurance company has the option to reduce or eliminate future disability payments in order to recover any overpayment balance that is not reimbursed.

FRAUD NOTICES

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

ARIZONA
For your protection, Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

CALIFORNIA
For your protection, California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

COLORADO
It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

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.

KENTUCKY
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.

MAINE, TENNESSEE AND WASHINGTON
It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

MARYLAND AND ARKANSAS
Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

MINNESOTA
A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NEW HAMPSHIRE
Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in NH Rev. Stat. Ann. §638:20.

NEW JERSEY
Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

OKLAHOMA
WARNING: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer makes any claim for the proceeds of an insurance policy containing any false, incomplete, or misleading information is guilty of a felony.

OREGON
It may be a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties could include imprisonment and fines, and may result in a denial of insurance benefits.

PENNSYLVANIA
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 subjects such person to criminal and civil penalties.

VIRGINIA
Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.

The statements contained in this form are true and complete to the best of my knowledge and belief.

X _____ **X** _____

Signature of the employee Date

PLEASE ATTACH A COPY OF YOUR DRIVER'S LICENSE OR ANOTHER DOCUMENT THAT VERIFIES YOUR DATE OF BIRTH.

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AUTHORIZATION FOR RELEASE OF INFORMATION (excluding psychotherapy notes)
(HIPAA COMPLIANT)
(to be signed and dated by the insured/claimant)

I authorize any licensed physician, any other medical practitioner or provider, pharmacist, pharmacy benefits manager, hospital, clinic, other medical or medically related facility, federal, state or local government agency including the Social Security Administration, insurance or reinsuring company, consumer reporting agency or employer having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me, and any non-medical information about me, (including any information, data or records regarding my Social Security, FICA earnings history, Worker's Compensation, State Disability, pension, credit, earnings and employment history) to give any and all such information to authorized representatives of Kansas City Life Insurance Company *excluding psychotherapy notes*, and including, but not limited to, any other mental or psychiatric records, medical, dental, hospital and pharmacy records (including psychiatric, alcohol, and drug abuse, and **HIV/AIDS*** information) which may have been acquired in the course of examination or treatment. I understand the information obtained by use of this authorization will be used by Kansas City Life Insurance Company and the above-described representatives to evaluate and adjudicate my current disability claim. The information may be redisclosed to: (a) any medical, investigative, financial or vocational specialist or entity, or any other organization or person, employed by or representing Kansas City Life Insurance Company, to assist with the evaluation and adjudication of my current disability claim, (b) a Social Security vendor that may assist me in filing a claim with the Social Security Administration, and (c) other insurance companies or their representatives to help investigate and adjudicate other insurance claims related to me. I understand Kansas City Life Insurance Company and the above- described representatives may release information to my treating physicians and current or prospective employers relating to restrictions, accommodations and possible return to work. I understand the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA's Privacy rules, or any other federal or state law.

This authorization is valid for two (2) years following the date of my signature. A photocopy of this authorization is as valid as the original. I understand my authorized representative or I have the right to request and receive a copy of this authorization and the information to which it pertains.

I understand I have the right to revoke this authorization by notifying Kansas City Life Insurance Company in writing, of my revocation. However, such revocation is not effective to the extent Kansas City Life Insurance Company has relied previously upon this authorization for the use or disclosure of my protected health information. I understand Kansas City Life Insurance Company cannot condition the payment of a claim on my signing this authorization. However, I understand my revocation of, or my failure to sign this authorization may impair Kansas City Life Insurance Company's ability to evaluate my current disability claim and as a result lack of required information may be a basis for denying that current disability claim for benefits.

*If you reside in **California**: this authorization excludes the release of Human Immunodeficiency Virus (HIV) and Autoimmune Deficiency Disorder (AIDS) information and test results. Separate authorizations signed by the insured claimant, or employee-claimant (for self-insured business) are required each time results are released.

*If you reside in **Connecticut, Maine or Massachusetts**: this authorization excludes the release of information about Human Immunodeficiency Virus (HIV) and Autoimmune Deficiency Disorder (AIDS). A separate authorization signed by the insured claimant, or employee-claimant (for self-insured business) are required each time results are released.

*If you reside in **Vermont**: this authorization EXCLUDES the release of any information about previously administered HIV-related tests, including but not limited to tests for HIV antibodies, T-Cell counts, AIDS or ARC. The proposed insured is NOT AUTHORIZING Kansas City Life Insurance Company to forward the results from any new test, requested by us, to any outside, non-affiliated company or entity not under specific contract with us to perform underwriting services, and Kansas City Life Insurance Company shall comply, as applicable with the provisions of Title 8, Section 4724 (20) of the Vermont Statutes.

Claimant name_____ Date of birth _____

Claimant signature *(or authorized representative)* _____ Date _____

Description of personal representative's authority *(if applicable)* _____
If signed by authorized representative, attach verification of identity.

KANSAS CITY LIFE
GROUP BENEFITS

APPLICATION FOR LONG TERM DISABILITY INCOME BENEFITS **Section 4**

KANSAS CITY LIFE INSURANCE COMPANY **Attending Physician's Statement**

To be completed by the Employee

Name of patient	Social Security number	Date of birth *(month/day/year)*

Address of patient City State/province ZIP

Employer's name *(include division, if applicable)*

I hereby authorize release of information on this form by the below named physician for the purpose of claim processing.	Signed *(patient)* _____	Date

To be completed by the Attending Physician *(The patient is responsible for the completion of this form without expense to the Company.)*

Patient's condition is the result of ☐ Illness ☐ Injury ☐ Pregnancy	Height
If pregnancy, what is the expected date of delivery? *(month/day/year)*	Weight

Is condition due to illness or an injury that is work related? ☐ Yes ☐ No

A. Diagnosis

Primary diagnosis _____ ICD-9 Code _____

Secondary diagnosis(es) _____ ICD-9 Code(s) _____

Subjective symptoms _____

Test Results (list all results, or enclose test)

Test _____ Date _____ Results _____

Test _____ Date _____ Results _____

Physical examination findings _____

FOR PREGNANCY DISABILITY ONLY:

Are there any present complications or anticipated difficulties in connection with:

a) Pregnancy ☐ Yes ☐ No Date of last menstrual period _____ Expected date of delivery _____

b) Delivery ☐ Yes ☐ No Actual date of delivery _____ ☐ Vaginal ☐ C-section

c) Postpartum ☐ Yes ☐ No

If "Yes" to any of these, please specify in detail

B. Treatments

Date you first treated this patient _____ Date you first treated this patient for this condition _____

Date of onset of this condition _____ Date of most recent treatment _____

How often has patient been seen/treated? _____ Date of next office visit _____

Has patient been referred to any other physician? ☐ Yes ☐ No Date(s) _____

If "Yes," name and address _____

_____ Specialty _____

Nature of treatment for this condition *(including surgery/medications)* _____

Was surgery performed? ☐ Yes ☐ No If "Yes," Date _____ Procedure _____ CPT Code _____

Was patient hospitalized for this condition? ☐ Yes ☐ No If "Yes," Date(s) admitted _____

Date(s) discharged _____

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Name and address of hospital(s) _____

_____

Progress *(please check one)* ☐ Recovered ☐ Improved ☐ Unchanged ☐ Retrogressed

C. Impairment

If the patient's ability to perform any of the following activities is limited by his/her disorder, please describe the extent of the limitation and its expected duration.

Standing _____

Walking _____

Sitting _____

Lifting/carrying _____

Reaching/working overhead _____

Pushing _____

Pulling _____

Driving _____

Keyboard use/repetitive hand motion _____

If the patient's vision is impaired, please describe the extent of the impairment _____

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

What is the psychiatric impairment *(if applicable)*?

- ☐ Inadequate information to make assessment.
- ☐ Essentially good functioning in all areas. Occupationally and socially effective.
- ☐ Slight difficulty in occupational functioning, but generally functioning well. Has some meaningful interpersonal relationships.
- ☐ Moderate impairment in occupational functioning. Limited in performing some occupational duties.
- ☐ Major impairment in several areas – work, family relations. Avoidant behavior, neglects family, is unable to work.
- ☐ Inability to function in almost all areas.

RETURN TO WORK PLAN

a) Have you discussed a return to work plan with your patient? ☐ Yes ☐ No

b) The date you released patient to return to work: *(month/day/year)* _____

☐ Full-time ☐ Reduced hours Number of hours: _____

c) Please identify your recommendations for any job modifications that would enable the patient to work.

_____

_____

Attending physician's name *(Please print or type.)* _____ Phone number _____

License number _____ Fax number _____

SSN or EIN _____ Degree _____ Specialty _____

Address _____ City _____ State _____ ZIP _____

Signature _____ Date _____

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