Humana.

APPLICATION FOR SHORT TERM DISABILITY INCOME BENEFITS

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

Section I **Employer's Statement** - to be completed by the **employer's** authorized representative.

Section II **Employee's Statement -** to be completed by the **employee** who is applying for Short Term Disability Benefits

Section III **Authorization to Obtain Information** - to be signed by the **employee**.

Section IV **Attending Physician's Statement -** to be completed by the Healthcare Provider who is treating the **employee.**

Mail or fax completed application to:

Humana Insurance Company
P.O. Box 14294
Lexington, KY 40512-4294
Fax Number: (855) 864-0530
Telephone Number: (877) 604-0072
Email: claimsubmission@groupclaims.com

Please verify if the employee qualifies for any other group benefits through Humana and submit the claim accordingly.

PLEASE SEE THAT ALL SECTIONS ARE FULLY COMPLETED AND SIGNED.

Mail or fax completed application to:
Humana Insurance Company
P.O.Box 14294
Lexington, KY 40512-4294
Fax Number: (855) 864-0530

Clear Form

APPLICATION FOR SHORT TERM DISABILITY INCOME BENEFITS

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Section I - Employer's Section

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)		Telephone Number ( )

A. Information About the Employer

Company's Name

Address (Street, City, State, Zip)

Name and Address of Division Where Employee Works (if different from above)

Group Policy Number	Class	Location

B. Information About the Employee

Date employee was hired

Date employee became insured under this plan

Is the employee a union member? ☐ Yes ☐ No
If Yes, name of union and local number:

What was the employee's regularly scheduled work week?

_____ Hours per Week _____ Scheduled workdays M - F Other: _____

IS EMPLOYEE ENROLLED IN HUMANA'S LONG TERM DISABILITY PLAN ? Yes ☐ ☐ No IF "YES," EFFECTIVE DATE _____

Was the employee's STD insurance issued on the basis of a Personal Health Statement? ☐ Yes ☐ No If "Yes, attach copy.

Was the employee insured under your prior STD policy? ☐ Yes ☐ No
If "Yes," please provide the inclusive date of coverage. From _____ Through _____

Was the employee on Qualified Family Leave when disability began? ☐ Yes ☐ No
Did STD & LTD insurance continue while on Family Leave? ☐ Yes ☐ No
Date Leave of Absence started under Family Leave Act: _____

C. Information Needed for Withholding and Reporting Taxes

What percent of this employee's STD benefit is taxable? _____%.
What percentage, if any, do you contribute towards the cost of the STD premium? _____%
Does the employee contribute towards the cost of the STD premium? ☐ Yes ☐ No. If "Yes," at what percent? _____%.
Is it on a ☐ Pre or ☐ Post-tax basis?
What percent of this employee's LTD benefits is taxable? _____%
Does the employee contribute towards the cost of the LTD premium? ☐ Yes ☐ No. If "Yes," at what percent? _____%
Is it on a ☐ Pre or ☐ Post-tax basis?

D. Information About the Claim

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.)

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 to return to work? _____
Full time? ☐ Yes ☐ No

E. Information About Salary

Employee's weekly/hourly rate of pay: $_____

Will/Is Employee receive(ing) Workers' Compensation Payments? ☐ Yes ☐ No

Weekly Amount: $_____ Date Payments Start: _____ Date Payments Will End: _____

Is employee receiving Salary Continuance? ☐ Yes ☐ No or Sick Leave? ☐ ☐

Weekly Amount: $_____ Date Payments Start: _____ Date Payments Will End: _____

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

Check the items below that relate to the employee's job and complete the information requested.
Select either majority of workday or sporadically.

Activity	Majority of workday (with standard breaks)		Sporadically throughout day	If sporadically circle time for each section below: Hours at one time	Total hours/8 hour
Sit	☐	or	☐	1 2 3 4 5 6 7 8	1 2 3 4 5 6 7 8
Stand	☐	or	☐	1 2 3 4 5 6 7 8	1 2 3 4 5 6 7 8
Walk	☐	or	☐	1 2 3 4 5 6 7 8	1 2 3 4 5 6 7 8

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

Activity	Never	Occasionally (1-33%)	Frequently (34-67%)	Constantly (68-100%)
Driving	☐	☐	☐	☐
Balancing	☐	☐	☐	☐
Bending at Waist	☐	☐	☐	☐
Kneeling/Crouching	☐	☐	☐	☐
Crawling	☐	☐	☐	☐
Climbing	☐	☐	☐	☐

Lift/Carry/Push/Pull: Task Description (Describe object moved and any mechanical assistance in the last column)					
Lifting		lbs.	lbs.	lbs.	
Carrying		lbs.	lbs.	lbs.	
Pushing/Pulling		lbs.	lbs.	lbs.	

Upper Extremity Activity (not load bearing)	**Specify right (R) or left (L) if not bilateral)**				**Describe task performed**
Fine manipulation (fingering, keyboard)	☐	☐	☐	☐	
Gross manipulation (grip/grasp, handle)	☐	☐	☐	☐	
Reach (extend arms) above shoulder	☐	☐	☐	☐	
Reach (extend arms) below shoulder at desk or workbench level	☐	☐	☐	☐	

G. 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.

H. Signature

Name (Please print or type) _____ *Title* _____

Signature _____ *Date* _____

( ) _____ ( ) _____

Area Code Telephone Number Area Code Fax Number

Mail or fax completed application to:
Humana Insurance Company
P.O.Box 14294
Lexington, KY 40512-4294
Fax Number: (855) 864-0530

APPLICATION FOR SHORT TERM DISABILITY INCOME BENEFITS

Humana.

Section II - Employee's Section

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:	Gender: ☐ Male ☐ Female	Date of Birth:	Social Security Number:
Address: (Street, City, State & Zip)	Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced		

Personal Cell Telephone Number: ( ) Alternate Telephone Number: ( )

May we have your authorization to leave confidential medical and benefit information on your personal cell phone? ☐ Yes ☐ No

Signature Date E-Mail Address:

E-Mail is used to provide important status updates.

B. For an Injury, answer the following questions

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

C. For Illness, Injury or Pregnancy, answer the following questions

Name of Healthcare Provider:	Date you were first treated by a Healthcare Provider: (MM/DD/YYY)
Address of Healthcare Provider: (Street, City, State & Zip)	Telephone 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?

Are you receiving or eligible for: ☐ Workers' Compensation ☐ State Disability ☐ No Fault Disability ☐ Other
If "Yes," show policy number: and name and address of insurer:

Weekly Amount: $ Date Payments Start: Date Payments Will End:

Is your condition related to work activities or your workplace? ☐ Yes ☐ No If "Yes," explain:

Have you filed, or do you intend to file a Workers' Compensation claim? ☐ Yes ☐ No If "No," explain:

D. Information About the Disability

Last day you worked before the disability:	Did you work a full day? ☐ Yes ☐ No If "No," explain:

Your Employer: (include division, if applicable)

If you have not returned to work, do you expect to? ☐ Yes ☐ No Date you were first unable to work:

Since that date, have you done any work? ☐ Yes ☐ No ☐ Part time ☐ Full time
If "Yes," please indicate dates worked, name of employer and amount earned:

Name of employer and amount earned.

E. 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 $ 20.00 per week). $ _____.__00.__ **IMPORTANT:** If you pay the entire cost of the STD premium, but on Post-tax basis per Section C of the Employer's Statement, you will not be able to request any federal income tax withholding from your check. Puerto Rico residents may not request withholding.

Note to residents of Iowa and the District of Columbia: Should you choose federal income tax withholding, your state requires us to withhold state income tax. We must withhold at a state mandated rate (which may be higher than you need) until we receive a signed state Tax Withholding Certificate from you. Please cont act your employer or st ate Tax Department to obtain the proper withholding form.

Note to residents of Nebraska, Rhode Island and South Carolina: Should you choose federal income tax withholding, your state requires us to withhold state income tax. We must withhold at a state mandated rate (which may be higher than you need) until we receive a signed federal Form W -4, Employee's Withholding Allowance Certificate, from you. You may go to www .irs.gov to obtain the proper withholding form.

Signature - Please read the statement that applies to your state of residence and sign the bottom of the second page.

With the exception of any source(s) of income reported above in this form, I certify by my signature that I have not received and am not eligible to receive any source of income, except for my disability benefits from this plan. Further, I understand that should I receive income of any kind or perform work of any kind during any period The Hartford has approved my disability claim, I must report all details to The Hartford, immediately. If I receive disability income benefits greater than those which should have been paid, I understand that I will be required to provide a lump sum repayment to the Plan. The Hartford has the option to reduce or eliminate future disability payments in order to recover any overpayment balance that is not reimbursed.

For residents of all states EXCEPT Arizona, Alabama, California, Colorado, Florida, Kentucky, Maine, Maryland, New Jersey, New York, Ohio, Oklahoma, Oregon, Pennsylvania, Puerto Rico, Tennessee, Virginia and Washington: 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.

For Residents of 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.

For Residents of Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

For Residents of California: 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.

For residents of 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 award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

For residents of 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.

For residents of Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim or an application for insurance 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.

For residents of 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 may include imprisonment, fines and denial of insurance benefits.

For Residents of Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit and who 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.

For residents of New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. Any person who includes any false or misleading information on an application for insurance policy is subject to criminal and civil penalties.

For residents of Ohio: Any person who, with intent to defraud or knowing he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

For residents of 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.

For residents of Oregon: 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 that the insurer relied upon is subject to a denial and/or reduction in insurance benefits and may be subject to any civil penalties available.

For residents of 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 hereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Signature - Please read the statement that applies to your state of residence and sign the bottom of the page.

For residents of Puerto Rico: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

For residents of 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.

For residents of New York: 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.

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

_____ _____

Signature Date

Electronic Funds Transfer (EFT) is our standard method of payment. When making our claim decision we may contact you to obtain your banking information.

Humana.

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I allow all doctors, hospitals, other health care providers, pharmacy, pharmacy benefit managers, government agencies (including, but not limited to, Federal, State or Local, and the Social Security Administration and Veterans Administration), insurers, employers, financial institutions, educational institutions, health plans, health insurance carriers, policyholders, contract holders, vendors, health and benefit insurers and administrators or their successors ("Records Holders") to give to and discuss with Humana Insurance Company ("Humana") and/or its Third Party Administrator ("TPA") and its representatives, the following personal, private, or privileged information, records, or documents related to:

Insured's Name (Please Print)	Date of Birth	Employer/Policyholder's Name:
_____	_____	_____

Any and all medical information or records, including medical histories, physical, mental, or diagnostic examinations, pharmaceutical records, and treatment notes, and including information regarding HIV/AIDS, communicable diseases, alcohol or substance abuse, and behavioral or mental health (but excluding psychotherapy notes); work and performance information and history, including job duties and earnings; information on any insurance coverage and claims filed, including all records and information related to such coverage and claims; financial information, including pension benefits and bank records; business transaction billing and payment records; academic transcripts; and any and all information concerning Social Security or other government benefits, including monthly benefit amounts, monthly payment amounts, entitlement dates, and information from my Master Beneficiary Record. The information obtained by use of this Authorization will be used by Humana and/or its TPA (including subsidiaries and affiliates) for the purpose of evaluating and administering my claim(s) for benefits and /or leave request(s) and/or request(s) for accommodation. Such information shall be referred to herein collectively as “My Information.”

I understand that once My Information has been disclosed to Humana and/or its TPA as permitted under this Authorization, it may be re-disclosed by Humana and/or its TPA as permitted by law or my further authorization. Without limiting the foregoing, I authorize Humana and/or its TPA to use or disclose My Information (i) to my employer for: a) functions related to accommodating my restrictions/limitations, including in accordance with law; b) responding to claims related to accommodation, adverse or discriminatory treatment related to my claim or condition; c) responding to complaints by me or my representative relating to benefits, leave or accommodation; d) responding to any litigation, agency or regulatory proceeding, grievance, alternative dispute resolution, or lawful subpoena (including regarding employment claims); e) federal, state, or other leave administration; f) fulfilling fiduciary obligations under my benefit plan; or (g) claim, other audits or benefit program reviews; (ii) to administrators or other service providers, including health and wellness vendors, of my employer’s benefit plan(s) and/or programs, including leave management, for plan, benefit, or program related functions or data aggregation and analysis; (iii) to any electronic claim systems or programs or third party vendors used for claims administration or processing or to any insurance broker to carry out functions related to my benefit plan/program or claim; (iv) to any health care professional who has treated or evaluated me or who may do so; (v) to other persons or entities performing business, medical, or legal services related to my claim; (vi) for other insurance, reinsurance or analytical purposes, including workers’ compensation insurance, Social Security Disability insurance, or subrogation or reimbursement purposes ; (vii) as may be lawfully required; (viii) as may be reasonably necessary to protect the personal safety of others or myself; (ix) as may be reasonably necessary to respond to regulatory or similar complaints; and (x) as may be reasonably necessary to prevent or detect perpetration of a fraud. I understand that My Information disclosed to Humana and/or its TPA and re-disclosed to others could include information regarding alcohol and substance abuse, HIV/AIDS, other communicable diseases, and behavioral and mental health records.

(Continue to next page)

I understand that once my Information is given out as allowed in this form, federal privacy laws may not protect it and it may be re-disclosed by Humana Insurance Company ("Humana") and/or its Third Party Administrator ("TPA"). I also understand that information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient. The Authorizations set forth herein expire two years from the date listed below, or upon my written revocation, if earlier, except as may be reasonably necessary to prevent or detect perpetration of a fraud, adjudicate a benefits claim, respond to regulatory or similar complaints, or protect the personal safety of others or myself. I understand that if Humana and/or its TPA is the administrator of my employer's self-insured disability program or leave program that my employer is entitled to receive my records without this Authorization. I understand that a revocation of this Authorization is not effective to the extent that any of my Record Holders or Humana and/or its TPA has relied on this Authorization or to the extent that Humana and/or its TPA has a legal right to contest a claim for benefits or to contest the policy. If I do not sign this Authorization, Humana and/or its TPA may not be able to review my claim and determine whether I am eligible for benefits. This may result in a delay or denial of my request for benefits.

The Information released under this Authorization can be submitted to Humana and/or its TPA electronically, by phone or fax, or by mail. I agree that a copy of this Authorization may be treated as a signed original. I understand that I am entitled to receive a copy of this Authorization upon request. If there is a conflict between a prior request for restriction on the disclosure of My Information and this Authorization, this Authorization will control.

NOTICE TO INFORMATION PROVIDERS:
The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family members genetic tests, the fact that an individual or an individuals' family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. Please note that it is appropriate under GINA to provide family medical history when an employee is requesting leave to care for a family member.

_____ _____

Signature of Claimant or Legal Representative **Date**

_____

Name and Relationship to Claimant *(if signed by Legal Representative)*

Form must be signed and dated.

Mail or fax completed application to:
Humana Insurance Company
P.O.Box 14294
Lexington, KY 40512-4294
Fax Number: (855) 864-0530

Clear Form

Humana.

Attending Physician's Statement – Initial

To be completed by the Provider (The patient is responsible for any expense related to the completion of this form)

Patient Last Name:	Patient First (or Preferred) Name:	Date of Birth:	Claim Id Number:

Condition

Patient's condition is a result of:
☐ Illness ☐ Injury
☐ Pregnancy

If illness or injury, is condition related to:
☐ Work Activity ☐ Motor Vehicle Accident
☐ Intentional/Self-Inflicted

If pregnancy, what is date of delivery?
__/__/____ (MM DD YYYY)
☐ Actual ☐ Estimated

Condition onset: __/__/____ (MM DD YYYY)

Date you first treated this patient: __/__/____ (MM DD YYYY)

First day recommended out of work:
__/__/____ (MM DD YYYY)

Office visit to complete this form:
__/__/____ (MM DD YYYY)
☐ In Person ☐ Telemedicine

Projected return to work date:
__/__/____ (MM DD YYYY)

Disabling Diagnosis(es) and Impact to Function

ICD-10 Code
Please provide most specific codes:

|__||__||__|.|__||__||__||__| and |__||__||__|.|__||__||__||__|

Description of corresponding symptoms

Please provide most specific code possible, one character per block, up to two code entries possible. Ex.: |X|#|#|.|#|#|#|#|

Co-Morbid Conditions with Impact to Diagnosis

☐ None ☐ Opioid Usage ☐ Psoriasis ☐ Mental Health
☐ Diabetes ☐ Heart Disease ☐ Asthma/Bronchitis ☐ Cognitive Impairment
☐ Hypertension ☐ Obesity ☐ Auto-Immune Disease
☐ COPD ☐ Arthritis ☐ Other _____

In your opinion is the patient competent to endorse checks and direct the use of proceeds? ☐ Yes ☐ No

Treatment Plan

☐ Conservative treatment ☐ Bed Rest ☐ Palliative care ☐ Hospice Care

☐ Hospitalization Admittance date: __/__/____ (MM DD YYYY) Discharge date: __/__/____ (MM DD YYYY)

☐ Next/Another appointment Date: __/__/____ (MM DD YYYY) ☐ In Person ☐ Telemedicine

☐ Physical/Occupational therapy |__| times per week ☐ until __/__/____ (MM DD YYYY) ☐ Actual ☐ Estimated

☐ Surgery Date: __/__/____ (MM DD YYYY) CPT Code(s): |__||__||__||__||__| and |__||__||__||__||__|
Please provide most specific code possible, one number per block, up to two code entries possible. Ex.: |#|#|#|#|#|

☐ Referral to a specialist Type: _____ Contact Info:_____

Current Medications (related to condition or impacting function)

☐ None ☐ Over counter medications: _____

☐ Prescription medications Name(s): _____

☐ Impacting function? ☐ Yes ☐ No If yes, why? _____

☐ Chemotherapy ☐ Radiation Start Date: __/__/____ (MM DD YYYY) End Date: __/__/____ (MM DD YYYY)

Please mail the completed form to:
Humana Insurance Company
P.O. Box 14294
Lexington, KY 40512-4294
Phone Number: (877) 604-0072

Humana.

Attending Physician's Statement – Initial

To be completed by the Provider (The patient is responsible for any expense related to the completion of this form)

Patient Last Name:	Patient First (or Preferred) Name:	Date of Birth:	Claim Id Number:

Level of Functionality (Based upon your medical findings and opinion, address the full range of your patient's abilities. We will conclude that there are no restrictions on function unless specified below.)

Expected duration of any restriction(s) or limitation(s) listed below THROUGH __/__/____
MM DD YYYY

In a workday the patient is able to: (select either Continuous or Intermittent)

	Continuously with standard breaks		Intermittently with standard breaks	If intermittent, enter time for each section below	
				Hours at one time	Total hours in a workday
Sit	☐	or	☐	|___|	|___|
Stand	☐	or	☐	|___|	|___|
Walk	☐	or	☐	|___|	|___|

Key: C = Continuously (5.5 – 8 hours) F = Frequently (2.5 – 5.5 hours) O = Occasionally (up to 2.5 hours) N = Never

Activity Ability	C	F	O	N	Activity Ability	Right/Left	C	F	O	N
☐ Drive	☐	☐	☐	☐	☐ Squat / Kneel		☐	☐	☐	☐
☐ Weight bearing	☐	☐	☐	☐	Hand Dominance	☐ R ☐ L				
☐ Climb	☐	☐	☐	☐	☐ Fine Manipulation	☐ R ☐ L	☐	☐	☐	☐
☐ Bend	☐	☐	☐	☐	☐ Gross Manipulation	☐ R ☐ L	☐	☐	☐	☐
☐ Max lift	____LBS	____LBS	____LBS	____LBS	☐ Reach above shoulder	☐ R ☐ L	☐	☐	☐	☐
☐ Max Carry	____LBS	____LBS	____LBS	____LBS	☐ Reach below shoulder	☐ R ☐ L	☐	☐	☐	☐

Completed or Planned Diagnostic Tests, Labs and Imaging (related to the disabling diagnosis)

Completed: ☐ X-ray __/__/____ ☐ MRI __/__/____ ☐ CT __/__/____ ☐ EKG __/__/____
MM DD YYYY MM DD YYYY MM DD YYYY MM DD YYYY

☐ ECHO __/__/____ ☐ EMG __/__/____ ☐ Lab Work __/__/____
MM DD YYYY MM DD YYYY MM DD YYYY

Findings of completed tests: ☐ No significant findings ☐ Confirmed diagnosis

Planned: ☐ X-ray ☐ MRI ☐ CT ☐ EKG ☐ ECHO ☐ EMG ☐ Lab Work Scheduled date __/__/____
MM DD YYYY

Provider Details

Provider Name: _____
Specialty: _____
EIN Number: _____
License Number: _____

Email: _____
Phone: (___) ___-____
Fax: (___) ___-____

Provider Signature: _____

Date: __/__/____
MM DD YYYY