Notice of Disability - Attending Physician Statement

securian FINANCIAL®

Securian Financial Group, Inc.
Minnesota Life Insurance Company
Austin Branch Office • P.O. Box 64114, St. Paul, MN 55164-0114
1-877-443-5854 • Fax 1-877-494-8401

CLAIM NUMBER

Please **print clearly** or **type** and answer all questions as completely as possible. Unanswered questions may require additional processing time. Please be sure to sign and date this form.

The claimant/patient is responsible for any expenses related to the completion of this form.

Patient Information

Patient's name (first, middle, last) | Date of birth (mo/day/yr)

Telephone number | Height | Weight | Blood pressure reading/date

Patient History

Date symptoms first appeared or accident occurred (mo/day/yr) | Date patient ceased work due to disability (mo/day/yr)

Is condition due to injury or illness arising out of patient's employment?

☐ Yes ☐ No If yes, which one? ☐ Injury ☐ Illness

Has patient ever had same or similar condition?

☐ Yes ☐ No If yes, state when and describe.

Names and addresses of other treating physicians

Diagnosis

Present diagnosis including any complications (describe fully)

Subjective symptoms

Nature and Dates of Service

Date of first visit (mo/day/yr) | Date of last visit (mo/day/yr) | Date of next visit (mo/day/yr)

Frequency of visits

☐ Weekly ☐ Monthly ☐ Other (specify):

Has patient been hospitalized?

☐ Yes ☐ No If yes, give dates. From (mo/day/yr): through (mo/day/yr):

Hospital name and address

Was surgery performed?

☐ Yes ☐ No If yes, provide date (mo/day/yr) and procedure:

Is patient currently enrolled in any type of rehabilitation program?

☐ Yes ☐ No If yes, what type of program? ☐ Cardiac ☐ Physical therapy ☐ Other (specify):

List current medications for disabling condition(s)

By furnishing this form or any other form, the Company does not admit that any coverage is in force nor waive any of its rights or defenses.

****See Reverse Side****

Cardiac - Functional Capacity (American Heart Association)

☐ Class 1 - No limitation ☐ Class 2 - Slight limitation ☐ Class 3 - Marked limitation ☐ Class 4 - Complete limitation

Describe the basis for the above classification

Physical Impairment (*as defined in Federal Dictionary of Occupational Titles)

☐ Class 1 - No limitation 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* (35 - 55%).
☐ Class 4 - Moderate limitation of functional capacity; capable of clerical/administration (sedentary*) activity (60 - 70%).
☐ Class 5 - Severe limitation of functional capacity; incapable of minimal (sedentary*) activity (75 - 100%).

Describe the basis for the above classification

Mental/Nervous Impairment

☐ 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).

Describe the basis for the above classification

Do you feel patient is competent to endorse and direct the use of proceeds thereof?

☐ Yes ☐ No

Progress

Patient has (check all that apply) ☐ Recovered ☐ Improved
☐ Unchanged ☐ Retrogressed ☐ Reached maximum medical improvement - impairment rating of: %

If recovered, date released to return to work (mo/day/yr)

Patient is (check one)
☐ Ambulatory ☐ Bed confined ☐ House confined ☐ Hospital confined

Patient is suitable candidate for

☐ Trial employment ☐ Full-time ☐ Part-time ☐ Work hardening ☐ Job retraining

Prognosis

	Regular work	Other work
Is patient totally disabled?	☐ Yes ☐ No If no, date released (mo/day/yr):	☐ Yes ☐ No If no, date released (mo/day/yr):
Do you expect a change in the future relating to patient's ability to work?	☐ Yes - Improvement ☐ Yes - Deterioration ☐ No	☐ Yes - Improvement ☐ Yes - Deterioration ☐ No
If improvement is expected, when will patient recover sufficient to perform duties?	☐ 1 - 3 months ☐ 4 - 6 months ☐ Never ☐ Other (specify):	☐ 1 - 3 months ☐ 4 - 6 months ☐ Never ☐ Other (specify):

If improvement is not expected, please explain.

Have you provided information for this patient to another insurance company or agency?

☐ Yes ☐ No If yes, list company/agency name, telephone number and claim number.

Company/agency name	Claim number	Telephone number

Comments

By furnishing this form or any other form, the Company does not admit that any coverage is in force nor waive any of its rights or defenses.

Signature of Attending Physician	
Name of attending physician (please print)	Degree
Physician address (street)	Telephone number
City, state, zip	Fax number
Print name of person completing this form	Title

For your protection, state laws require 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. Any insurance company or agent of an insurance company who knowingly attempts to defraud a policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Division of Insurance.

SIGN HERE >	**Signature of attending physician** X	Date (mo/day/yr)

By furnishing this form or any other form, the Company does not admit that any coverage is in force nor waive any of its rights or defenses.