Attending Physician's Statement - Accident or Sickness

Disability/Hospital Claim Form

This side must be completed by the attending physician

North Carolina Mutual Life Insurance Company
Durham, North Carolina 27701

Please Print

Name of patient ______________________ Date of Birth ______________________
Month Day Year

Patient's address ____
Street City State Zip Code

1. History

a. When did symptoms first appear or accident happen? Month ________ Day ________ Year ________
b. Date patient ceased work because of disability. Month ________ Day ________ Year ________
c. Has patient ever had same or similar condition? ______ Yes ______ No If "yes" state when and describe
____
____
d. Is condition due to injury or sickness arising out of patient's employment? _____ Yes _____ No _____ Unknown
e. If condition due to automobile accident, indicate state in which it occurred ______________________
f. Names and addresses of other treating physicians ______________________
____

2. Diagnosis

a. Date of last examination Month ________ Day ________ Year ________
b. Diagnosis (including any complications) ______________________
____
c. If disability is due to pregnancy what is expected/was delivery date? Month ________ Day ________ Year ________
d. Please describe any complications that would extend this disability longer than for a normal pregnancy. ________
____
e. Subjective symptoms ______________________
f. Objective findings (including current X-rays, EKGs, Laboratory Date and any Clinical findings) ________
____

3. Date of Treatment

a. Date of first visit Month ________ Day ________ Year ________
b. Date of last visit Month ________ Day ________ Year ________
c. Frequency Weekly ________ Monthly________ Other (specify) ________
d. How long was or will patient be continuously totally disabled (*unable to work*)? Month ________ Day ________ Year ________
e. How long was or will patient be partially disabled? Month ________ Day ________ Year ________

4. Nature of treatment (including surgery and medication prescribed, if any) ________

____
a. Charges for this procedure and date performed. ______________________

5. Progress

a. Has patient _____ Recovered? _____ Improved? _____ Unchanged? _____ Retrogressed?
b. Is patient _____ Ambulatory? _____ House confined? _____ Bed confined? _____ Hospital confinement?
c. Has patient been hospital confined? _____ Yes _____ No If "yes" give name and address of hospital? ________
____ Confined from ________ through ________

6. Cardiac (if applicable)

a. Functional capacity _____ Class 1 (No limitation) _____ Class 2 (Slight limitation)
(American Heart Association) _____ Class 3 (Marked limitation) _____ Class 4 (Complete limitation)
b. Blood pressure (last visit) ________ Systolic ________ Diastolic ________

Date	Name of Attending Physician (please print)	Phone Number	Tax ID Number

Address	City or Town	State	Zip Code

Signature of Attending Physician ______________________

ASSIGNMENT OF INSURANCE BENEFIT: I hereby authorize payment directly to the above named doctor of the Surgical Benefits otherwise payable to me but not to exceed the doctor's regular charges for this surgical procedure. I understand I am responsible to the doctor for charges not covered by this assignment.

Date ______________________ Patient's Signature ______________________

WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

POLICYHOLDER'S REPORT

Please Print *POLICYHOLDER COMPLETE THIS SIDE*

Failure to complete all questions will delay claim

POLICY NUMBER(S)

1. Write only the policy numbers on which you are making this claim.
2. Fill in your name (Insured) ______________________ Age ________
3. a. Insured's address ______________________ City ______________ State _____ Zip _______
   b. Insured's Social Security No. ______ – ______ – ______
4. Fill in your telephone number and area code. Area Code (   ) Telephone Number ______________
5. What were you treated for? (Please check) ________ Sickness or ________ Accident
6. Describe the sickness or accident in your own words. ______________________
7. When did symptoms first appear or accident happen? ________ Month ________ Day ________ Year
8. What date did a doctor first treat you for this sickness or accident? ________ Month ________ Day ________ Year
9. a. Did you ever have these symptoms before? (Check one) ______ Yes ______ No
   If the answer is yes, when were they noticed or treated in the last 2 years?
   b. Please list the dates here. ______________________
   c. Previous Hospital Confinements. ______________________
10. Did you stay in the hospital for this sickness or accident? (check one) ______ Yes ______ No
    If yes, what is the name and address of the hospital? (Attach itemized bill) ______________________
11. On what date were you first able to do any part of your work? ______________________
12. Give first date you did not work because of this sickness or injury. ______________________
13. Are you now totally unable to engage in any work, occupation or business? ______ Yes ______ No
14. What is your occupation? ______________________
15. Name and address of employer. ______________________
16. Employer's telephone number. (______) ______________________
17. Name of other companies with whom you have accident, health or hospital insurance. ______________________
18. Who is the family doctor and what other doctors have you seen in the last two years?

Family Doctor (Name and Address)	For how long	Other Doctors (Name and Address	For How Long

AUTHORIZATION FOR PATIENT'S RECORD

I, the undersigned, do hereby authorize any hospital, physician, insurance company, employer or association to furnish to North Carolina Mutual Life Insurance Company, their representatives, Equifax, Inc., or any other representative, any and all information with respect to any illness or injury, medical history, consultation, prescription or treatment and copies of all hospital or medical records (or photostats thereof if requested). A photostatic copy of this Authorization shall be considered as effective and valid as the original. Authorization valid for 12 months.

Insured must sign here X ______________________ Date ______________

(IF MINOR - PARENT MUST SIGN

DOCTOR MUST COMPLETE THE OTHER SIDE