

**Group Marketing Services, Inc.**  
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**WEEKLY INDEMNITY BENEFITS**

**PHYSICIAN'S STATEMENT**

PATIENT'S NAME:

PATIENT'S BIRTHDATE:

1. NATURE OF CONDITION:  SICKNESS OR  INJURY OR  PREGNANCY OR  OTHER; EXPLAIN

2. IS THE DISABLING CONDITION DUE TO, OR RELATED TO, THE EMPLOYEE'S EMPLOYMENT?  YES OR  NO

3. DIAGNOSIS:

4. WHEN DID SYMPTOMS FIRST APPEAR OR ACCIDENT OCCUR?

5. WHEN DID PATIENT FIRST CONSULT YOU FOR THIS CONDITION?

6. DESCRIBE ANY OTHER DISEASE OR INFIRMITY AFFECTING PRESENT CONDITION:

7. NATURE OF SURGICAL OR OBSTETRICAL PROCEDURE IF ANY:

8. DATES OF TREATMENT AND NATURE OF TREATMENT OTHER THAN SURGICAL:

9. IF HOSPITALIZATION OCCURRED, PROVIDE NAME AND ADDRESS OF FACILITY:

10. HAS PATIENT EVER HAD SAME OR SIMILAR CONDITIONS? IF YES, PLEASE DESCRIBE:

11. IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION:  YES OR  NO

12. HOW LONG WAS OR WILL PATIENT BE CONTINUOUSLY TOTALLY DISABLED (UNABLE TO WORK)?

PLEASE PROVIDE DATES: FROM: TO:

13. PATIENT CAN RETURN TO WORK ON: \_\_\_\_\_  WITH RESTRICTIONS OR  WITH NO RESTRICTIONS

RESTRICTIONS:

I AUTHORIZE THE RELEASE TO ASSURITY LIFE INSURANCE COMPANY OF ANY AND ALL MEDICAL RECORDS PERTAINING TO THE ABOVE PATIENT.

DATE:

SIGNED:

INDIVIDUAL PRACTITIONER'S SS/TIN/NPI #:

DEGREE:

( )

PHONE NUMBER

(CITY / STATE / ZIP)