Group Marketing Services, Inc.

P.O. BOX 19040 • Kalamazoo MI 49019-0040 • (269)343-2611

WAIVER OF PREMIUM (LIFE) CLAIM FORM

TO BE COMPLETED BY PHYSICIAN

1. PATIENT'S NAME:
2. PATIENT'S BIRTH DATE:

3. HISTORY
   - (a) When did symptoms first appear or accident occur?.................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
   - (d) Is condition due to injury or sickness arising from patient's employment? ☐ YES ☐ NO ☐ UNKNOWN

4. DIAGNOSIS
   - (a) Date of last examination ....Month________________________ Day_______________ Year_________________
   - (b) Diagnosis (including any complications): ....________________________
   - (c) Nature of condition: ....☐ SICKNESS ☐ INJURY ☐ OTHER; EXPLAIN
   - (d) Subjective symptoms ....________________________
   - (e) Objective findings (Including current X-rays, EKG's, Laboratory Data and any clinical findings)________________________

5. DATES 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) Is patient still under your care for this condition? ....☐ YES ☐ NO

6. NATURE OF TREATMENT (Including surgery and medications prescribed, if any)

7. PROGRESS
   - (a) Has patient... ☐ RECOVERED ☐ IMPROVED ☐ UNCHANGED ☐ UNCHANGED
   - (b) Is patient .... ☐ AMBULATORY ☐ HOUSE CONFINED ☐ BED CONFINED ☐ HOSPITAL CONFINED
   - (c) Has patient been hospital confined .... ☐ YES ☐ NO

8. CARDIAC (If applicable)
   - (a) Functional Capacity .... ☐ CLASS 1 (No limitation) ☐ CLASS 2 (Slight limitation) ☐ CLASS 3 (Marked limitation) ☐ CLASS 4 (Complete limitation)
   - Blood Pressure (last visit) .... (American Heart Ass'n)__________________________________(Systolic/Diastotic)

9. PHYSICAL IMPAIRMENT (*as defined in Federal Dictionary of Tides)
   - ☐ CLASS 1 – No limitation of functional capacity: capable of heavy work* No restriction. (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/administrative (sedentary*) activity. (60 – 70%)
   - ☐ CLASS 5 – Severe limitation of functional capacity: incapable of minimum (sedentary*) activity. (75 – 100%)

   Remarks:

10. MENTAL / NERVOUS IMPAIRMENT (IF APPLICABLE)
    - (a) Define "Strees" as it applies to this claimant:
    - (b) What stress and problems in interpersonal relations has claimant had on job?
      - ☐ 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, physiological, personal and social adjustment (severe limitations)

    Remarks:
    - (c) Do you believe the patient is competent to endorse checks and direct the use of the proceeds thereof?.............. ☐ YES ☐ NO

11. PROGNOSIS

	PATIENT'S JOB		ANY OTHER WORK
(a) Is patient now totally disabled?...	☐ YES ☐ NO		☐ YES ☐ NO
(b) What duties of patient's job is he/she incapable of performing?			
(c) Do you expect a fundamental of marked change in the future?	☐ YES ☐ NO		☐ YES ☐ NO
(1) If Yes, when will patient recover sufficiently to perform duties?............... ______ Mo. Day Year	☐ 1 mo. ☐ 3-6 mos ☐ 1-3 mos. ☐ Never	______ Mo. Day Year	☐ 1 mo. ☐ 3-6 mos. ☐ 1-3 mos. ☐ Never
(2) If No, please explain			

12. REHABILITATION

	PATIENT'S JOB		ANY OTHER WORK
(a) Is patient a suitable candidate for further rehabilitation services? (i.e. cardio pulmonary program, speech therapy, etc.)	☐ YES ☐ NO		☐ YES ☐ NO
(b) Can present job be modified to allow for handling with impairment?..	☐ YES ☐ NO		
(c) When could trial employment commence? .. ______ Mo. Day Year	☐ Full Time ☐ Part Time	______ Mo. Day Year	☐ Full Time ☐ Part Time

DATE: SIGNED:

INDIVIDUAL PRACTITIONER'S SS/TIN/NPI #: DEGREE:

( )

PHONE NUMBER (CITY / STATE / ZIP)