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)