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		☐ 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	☐ Full Time	☐ Part Time

DATE: SIGNED:

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

( )

PHONE NUMBER (CITY / STATE / ZIP)