





**Employer's Statement**

Employee's Name		Social Security No.	Hire Date	Insurance Eff. Date	Occupation	Class
Employer's Name and Address					Amount of Weekly Disability Benefit	
Date Last Worked	Date Returned	Base Salary	Hours Worked Per Week	Voluntary Buy-Up? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, amount: _____		
Workers' Comp Claim Filed? <input type="checkbox"/> Yes <input type="checkbox"/> No		Amount of Life Insurance in Force:			Premium Paid to Date:	
Claimant Received:		Through Date		Premium Contribution %		
<input type="checkbox"/> Salary Continuation/PTO		____/____/____		Employer _____% Employee _____%		
<input type="checkbox"/> Vacation		____/____/____		Employee's Premium for this Coverage Pre-Taxed? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Sick Pay		____/____/____				
Signature	Title	Date	Telephone Number ( )	Fax Number ( )		

**Attending Physician's Statement** *(Please print)*

(Must be completed in full at no expense to MedMutual Life)

Patient's Name	Address	Date of Birth / /	<input type="checkbox"/> Male <input type="checkbox"/> Female
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1. Symptoms result from:  Injury  Illness
2. Is condition work related?  Yes  No
3. Diagnosis and complications, if any: \_\_\_\_\_ ICD9-CM \_\_\_\_\_
4. Date symptoms first appeared or date of accident: \_\_\_\_/\_\_\_\_/\_\_\_\_
5. Date patient first consulted you for this condition: \_\_\_\_/\_\_\_\_/\_\_\_\_
6. Most recent treatment date: \_\_\_\_/\_\_\_\_/\_\_\_\_
7. Describe any other disease or complications affecting present condition: \_\_\_\_\_  
\_\_\_\_\_
8. Date and nature of surgical or obstetrical procedure, if any: \_\_\_\_\_
9. If maternity, give estimated or actual date of delivery: \_\_\_\_/\_\_\_\_/\_\_\_\_  Estimated  Actual  Vaginal  C-Section
10. Give all treatment dates and nature of treatment other than surgical: \_\_\_\_\_  
\_\_\_\_\_
11. Has patient been hospitalized?  Yes  No If yes, dates of confinement: \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_
12. Name and address of hospital: \_\_\_\_\_
13. Has the patient ever had the same or similar condition?  Yes  No If yes, state when and describe: \_\_\_\_\_  
\_\_\_\_\_
14. Is patient still under your care?  Yes  No If no, give discharge date and degree of recovery: \_\_\_\_\_  
\_\_\_\_\_
15. Is patient under the care of another physician?  Yes  No If yes, provide name and address: \_\_\_\_\_  
\_\_\_\_\_
16. **Dates patient was/will be continuously disabled:**  
**In his own occupation:** \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_ **In any occupation:** \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_
17. **Patient can return to work on:** \_\_\_\_/\_\_\_\_/\_\_\_\_  Full Time  Part Time  With restrictions  
If applicable, describe part time hours/restrictions: \_\_\_\_\_
18. In your opinion, is patient able to perform another job on a full or part-time basis?  Yes  No  
If yes, advise number of hours/level of work capacity (ie sedentary, light duty, etc): \_\_\_\_\_
19. In your opinion, is patient a candidate for rehabilitation?  Yes  No
20. If patient is diagnosed as terminal, life expectancy is:  6 months or less  12 months or less  Other \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Name *(Please Print)*: \_\_\_\_\_ Specialty: \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_



**MEDMUTUAL LIFE™**  
A Medical Mutual Company

## Fraud Notices

The laws of some states require us to furnish you with the following notice:

**For residents of all states except California, Florida, New Jersey, New York, Pennsylvania, Utah, Vermont, Virginia and Washington; WARNING:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person, or knowing that he is facilitating commission of a fraud, submits incomplete, false, fraudulent, deceptive or misleading facts or information when filing an insurance application or a statement of claim for payment of a loss or benefit commits a fraudulent insurance act, is/may be guilty of a crime and may be prosecuted and punished under state law. Penalties may include fines, civil damages and criminal penalties, including confinement in prison. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant or if the applicant conceals, for the purpose of misleading, information concerning any fact material thereto.

**CALIFORNIA RESIDENTS** – For your protection, California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**FLORIDA RESIDENTS** – Any person knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or application containing false, incomplete, or misleading information is guilty of a felony of the third degree.

**NEW JERSEY RESIDENTS** – Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

**NEW YORK RESIDENTS** – Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

**PENNSYLVANIA and UTAH RESIDENTS** – Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing materially false information or conceals for the purpose of misleading, information concerning any material fact thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**VIRGINIA RESIDENTS** – Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person, or knowing that he is facilitating commission of a fraud, submits incomplete, false, fraudulent, deceptive or misleading facts or information when filing a statement of claim for payment of a loss or benefit may have violated state law, is guilty of a crime and may be prosecuted and punished under state law. Penalties may include fines, civil damages and criminal penalties, including confinement in prison. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant or if the applicant conceals, for the purpose of misleading, information concerning any fact material thereto.

**VERMONT RESIDENTS** – Any person who knowingly presents a false or fraudulent claim for payment of a loss or knowingly makes a false statement in an application for insurance may be guilty of a criminal offense under state law.

**WASHINGTON RESIDENTS** – Any person who knowingly provides false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company commits a crime. Penalties include imprisonment, fines, and denial of insurance benefits.