

Group Life Disability Benefit Attending Physician's Statement

1 To Be Completed By Employee

Employer's Name															Control Number					
First Name										MI	Last Name									
Social Security Number					Date of Birth (MM DD YYYY)					Gender										
										☐ Male ☐ Female										
Street															Suite					
City										State		ZIP Code								
Occupation																				

I hereby authorize the release of information requested on this form by the below named physician for the purpose of claim processing.

Employee Signature X Date (MM DD YYYY)

The employee is responsible for the completion of this form without expense to Prudential.

2 To Be Completed By Attending Physician

Clinical Diagnosis										ICD-9 Code					Pregnancy EDC (MM DD YYYY)				
Primary																			
Secondary															Pregnancy Actual Delivery Date (MM DD YYYY)				
Secondary																			
Relevant test procedures performed (Please provide results)																			
Surgical Procedure(s) Performed (Please be specific)										Date of Procedure (MM DD YYYY)									
Current Medications																			



--	--	--	--	--	--	--	--	--

2 Attending Physician Information (Cont'd.)

Was Claimant hospitalized? ☐ Yes ☐ No

If yes, please provide name and address of hospital

If hospitalized, give dates:

From (MM DD YYYY)

--	--	--	--	--	--	--	--

To (MM DD YYYY)

--	--	--	--	--	--	--	--

Other Treating Physicians or Consultants

Name of Attending Physician (Please print)

First Name

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Last Name

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Specialty

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Telephone Number

--	--	--	--	--	--	--	--	--	--	--	--

First Name

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Last Name

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Specialty

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Telephone Number

--	--	--	--	--	--	--	--	--	--	--	--

Do you feel the claimant is competent to endorse checks and direct the use of proceeds? ☐ Yes ☐ No

Nature of Medical Impairment/Limitation (Please specify nature of corresponding loss of function)

Date when significant loss of function occurred: (MM DD YYYY)

--	--	--	--	--	--	--	--

Are there corresponding medical restrictions? (i.e., What activities should the claimant not perform because of a significant risk to self or others?)

Target Date (MM DD YYYY)

--	--	--	--	--	--	--	--

Prognosis for Return to Function/Return to Work

Return to Work Plan (Please describe)

--	--	--	--	--	--	--	--	--

2 Attending Physician Information (Cont'd.)

Describe medical obstacles to return to work

Are there any non-medical factors that have a significant impact on functional abilities (i.e., interpersonal, financial, family)?

Work-related illness or injury? ☐ Yes ☐ No

Was condition caused by a MVA? ☐ Yes ☐ No

If MVA, in what state did it occur?

--	--

First Visit:
(MM DD YYYY)

--	--	--	--	--	--	--	--

Last Visit:
(MM DD YYYY)

--	--	--	--	--	--	--	--

Frequency of Visits

--

What Job Category best describes the claimant's functional abilities? (Please check the appropriate box)

☐ **Sedentary**

Negligible Weight
Mostly Sitting

☐ **Light**

Up to 10 lbs. frequently
Up to 20 lbs. occasionally
and/or
Frequent Walk/Stand
and/or
Constant Push/Pull

☐ **Medium**

Up to 25 lbs. frequently
Up to 50 lbs. occasionally

☐ **Heavy**

25 to 50 lbs. frequently
50 to 100 lbs. occasionally

☐ **Very Heavy**

More than 50 lbs. frequently
100 lbs. occasionally

☐ **Other** (Please describe)

--

3 Physician Information

First Name

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

MI

--

Last Name

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Primary Telephone Number

--	--	--	--	--	--	--	--

Fax Number

--	--	--	--	--	--	--	--

Office Address

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Suite

--	--	--	--

City

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

State

--	--

ZIP Code

--	--	--	--	--	--	--	--

Specialty

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

4 Fraud Notice

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

Physician
Signature

X

Date (MM DD YYYY)

--	--	--	--	--	--	--	--	--

