DISABILITY CLAIM FORM
The Benefits Center
P.O. Box 100158, Columbia, SC 29202-3158
Pacific Time Zone Toll-free: 1-877-851-7637 Fax: 1-877-851-7624
All Other Time Zones Toll-free: 1-800-858-6843 Fax: 1-800-447-2498
Call toll-free Monday through Friday, 8 a.m. to 8 p.m. (Eastern Time).

ATTENDING PHYSICIAN STATEMENT (PLEASE PRINT)

PART I: TO BE COMPLETED BY PATIENT

Name of Patient (Last Name, Suffix, First Name, MI) | Social Security Number

Date of Birth (mm/dd/yy) | Home Telephone Number | Employer Telephone Number

Employer Name: Cummins Inc. (Policy 1216655)

PART II: TO BE COMPLETED BY PHYSICIAN OR TREATING PROVIDER

Instructions: Please complete, sign and date this statement. The purpose of this report is to assist us in making a disability determination. If this claim is related to a normal pregnancy, complete Section A. Otherwise, please complete all applicable sections of this form and provide copies of supporting reports, such as office notes, medical records, consultations and/or testing. In all situations, please complete the signature block at the bottom of this form.

A. Complete this section for normal pregnancy, then go to section C

Expected Delivery Date (mm/dd/yy):	Actual Delivery Date (mm/dd/yy):	Delivery Type: ☐ Vaginal ☐ C-Section	Date of first visit for this pregnancy (mm/dd/yy):	Date Hospitalized (mm/dd/yy):

Did you advise your patient to stop working? ☐ Yes ☐ No If yes, on what date (mm/dd/yy)?

Diagnosis:	ICD9 Diagnosis Code:	Height:	Weight:	Blood Pressure: As of date (mm/dd/yy):

B. Complete this section for all conditions except normal pregnancy

Patient Information

Height:	Weight:	Date of first visit for this current condition(s) (mm/dd/yy):	Did you advise your patient to stop working? ☐ Yes ☐ No If yes, on what date (mm/dd/yy)?

Has the patient been treated for the same/similar condition in the past? ☐ Yes ☐ No ☐ Unknown

If yes, please provide treatment dates (mm/dd/yy): From Through

Is the patient's condition due to injury or sickness involving the patient's employment? ☐ Yes ☐ No ☐ Unknown

Diagnosis

What is the primary diagnosis preventing the patient from working?

Please include primary ICD-9 or DSM IV Multi-Axial diagnoses codes	ICD9:

DSMIV: I	II	III	IV	V

What other conditions prevent the patient from working? ☐ NA

Secondary ICD-9s:	Diagnosis:
Secondary ICD-9s:	Diagnosis:

Are there any cognitive deficits or psychiatric conditions that impact function? ☐ Yes ☐ No
If yes, please provide restrictions and limitations:

Date of last examination (mm/dd/yy):	Date of next examination (mm/dd/yy):

What symptoms is your patient reporting about his/her condition?

What diagnostic or clinical findings support your diagnosis?

What diagnostic or clinical findings support your patient's work restrictions and limitations?

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ATTENDING PHYSICIAN STATEMENT (Continued)

Patient's Name (Last Name, Suffix, First Name, MI) | Date of Birth (mm/dd/yy)

Treatment

What is your treatment plan?

When do you expect the patient to improve to return to work?

Medications (Please attach medication log)

Has the patient been hospitalized? ☐ Yes ☐ No If yes, date hospitalized (mm/dd/yy): through (mm/dd/yy):

Facility Name

Address

City | State | Zip

Was surgery performed? ☐ Yes ☐ No | If yes, what procedure was performed? | Date Surgery Performed (mm/dd/yy):

Is the patient still under your care? ☐ Yes ☐ No | If no, final date of treatment:

Other Providers: Are you aware of or have you referred your patient to other treating providers? If yes, please provide complete name, contact information and specialty of any other treating physicians or hospitals.

Name	Specialty	Address	Phone #

Functional Capacity This is your estimate of your patient's functional capacity based on your knowledge of the patient. This information is important to assess your patient's eligibility for disability benefits.

Patient's ability to: *(Please check)*

	Never 0%	Occasionally 1-33%	Frequently 34-66%	Continuously 67-100%
Sit	☐	☐	☐	☐
Stand	☐	☐	☐	☐
Walk	☐	☐	☐	☐

Patient's ability to perform: *(Please Check)*

	Never 0%		Occasionally 1-33%		Frequently 34-66%		Continuously 67-100%	
	R	L	R	L	R	L	R	L
Fine Finger movements	☐	☐	☐	☐	☐	☐	☐	☐
Hand/eye coordinated movements	☐	☐	☐	☐	☐	☐	☐	☐
Pushing/Pulling	☐	☐	☐	☐	☐	☐	☐	☐

Dominant Hand ☐ Right ☐ Left

Patient's ability to: *(Please Check)*

	Never 0%	Occasionally 1-33%	Frequently 34-66%	Continuously 67-100%
Climb	☐	☐	☐	☐
Twist/bend/stoop	☐	☐	☐	☐
Reach above shoulder level	☐	☐	☐	☐
Operate heavy machinery	☐	☐	☐	☐

Patient's ability to lift/carry: *(Please Check)*

	Never 0%	Occasionally 1-33%	Frequently 34-66%	Continuously 67-100%
Up to 10 lbs.	☐	☐	☐	☐
11 to 20 lbs.	☐	☐	☐	☐
21 to 50 lbs.	☐	☐	☐	☐
51 to 100 lbs.	☐	☐	☐	☐

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ATTENDING PHYSICIAN STATEMENT (Continued)

Patient's Name (Last Name, First Name, MI, Suffix) | Date of Birth (mm/dd/yy)

Return to Work Assessment

Have you advised the patient to return to work? ☐ Yes ☐ No | If yes, expected return to work date (mm/dd/yy): ☐ Full Time ☐ Part Time | Hours per day

If yes, please indicate any ongoing restrictions and limitations in the space provided below.
If no, please indicate the restrictions and limitations that prevent the patient from returning to work in the space provided below.

CURRENT RESTRICTIONS (activities patient should not do)

CURRENT LIMITATIONS (activities patient cannot do)

Do you support your patient's return to work within the restrictions and limitations you provided? ☐ Yes ☐ No | If yes, as of (mm/dd/yy):

If no, when do you expect improvement in the patient's functional capacity?

FRAUD NOTICE: Any person who knowingly files a statement of claim containing false or misleading information is subject to criminal and civil penalties. This includes Attending Physician portions of the claim form.

C. Signature of Attending Physician

The above statements are true and complete to the best of my knowledge and belief.

Physician Name (Last Name, First Name, MI, Suffix) Please Print

Medical Specialty | Degree

Address

City | State | Zip

Telephone Number | Fax Number | Physician's Tax ID Number:

Are you related to this patient? ☐ Yes ☐ No
If yes, what is the relationship?

Signature of Physician | **Date**

X

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Please sign and return this authorization to The Benefits Center at the address above. You are entitled to receive a copy of this authorization. This authorization is designed to comply with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.

Authorization

I authorize health care professionals, hospitals, clinics, laboratories, pharmacies and all other medical or medically related providers, facilities or services, rehabilitation professionals, vocational evaluators, health plans, insurance companies, third party administrators, insurance producers, insurance service providers, credit bureaus, the MIB Group, Inc., GENEX Services, Inc., The Association of Life Insurance Companies (which operates the Health Claims Index and the Disability Income Record System), professional licensing bodies, employers, attorneys, financial institutions and/or banks, and governmental entities;

To disclose information, whether from before, during or after the date of this authorization, about my health, including HIV, AIDS or other disorders of the immune system, use of drugs or alcohol, mental or physical history, condition, advice or treatment (except this authorization does not authorize release of psychotherapy notes), prescription drug history, earnings, financial or credit history, professional licenses, employment history, insurance claims and benefits, and all other claims and benefits, including Social Security claims and benefits;

To the following persons: Unum Group and its subsidiaries, Unum Life Insurance Company of America, Provident Life and Accident Insurance Company, The Paul Revere Life Insurance Company, and persons who evaluate claims for any of those companies ("Unum"), employee benefit plans sponsored by my employer and any person providing services to, or insurance benefits on behalf of, such plans, and to anyone who provides services, including the evaluation of claims, related to benefits offered by Unum, my employer, or the Social Security Administration ("Authorized Recipients");

For the purposes of evaluating and administering claims, including assistance with return to work. Unum also may rely on this authorization for one year, or as otherwise permitted by law, to disclose information about me to the Authorized Recipients so they may conduct health care operations, claims payment, administrative, and audit functions related to my benefit plans.

Information authorized for use or disclosure may include information which may indicate the presence of a communicable or non-communicable disease.

If I do not sign this authorization or if I alter or revoke it, Unum may not be able to evaluate my claim(s), which may lead to my claim(s) being denied. I may revoke this authorization at any time by sending written notice to the address above. I understand that revocation will not apply to any information that is requested prior to Unum receiving notice of revocation.

The privacy protections established by HIPAA may not apply to information disclosed under this authorization, but other privacy laws do apply. Information disclosed under this authorization may be redisclosed only as permitted or required by law, including state fraud reporting laws. For evaluation and administration of claims, this authorization is valid for two years or the duration of my claim.

_____ _____
Insured's Signature Date Signed

_____ _____
Printed Name Social Security Number

I signed on behalf of the Insured as _____ (Relationship). If Power of Attorney Designee, Guardian, or Conservator, please attach a copy of the document granting authority.