



Supplementary Statement of Disability Long Term Disability Insurance

GE Financial Assurance
Employer Services Group

GE Group Life Assurance Company
100 Bright Meadow Boulevard
PO Box 1955
Enfield, CT 06083-1955

Must Be Completed in Full at No Expense to GE Group Life Assurance Company

Employee Statement

Claimant's Full Name (Please Print)

Group Account Number

1. Have you returned to any work since you were disabled? No Yes Date _____ Part-time Full-time

2. Do you expect to return to work in the near future? No Yes Approximate date _____ Part-time
 Full-time

3. Have there been any changes in your condition in the past year?
 Remains the same Has worsened Has improved

4. Have there been any changes in your life style? No Yes If yes, please explain _____

Are you living: At home In an assisted living facility (Address) _____
 In a convalescent facility (Address) _____

5. Activities of daily living.

Are you able to: Ambulate without assistance Leave your home Drive

6. Are you currently participating in any

Part-time work Volunteer work Study program Therapy

If "yes" to any of the above please explain: _____

7. Are you now eligible for, have you applied for, or are you now receiving income from:

	Yes	No	Amount of Income	Period (Wk, Bi-Wk or Mo)	Date Application Filed	Date Income Began	Date Income Ended
Primary Social Security	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____	per _____	____/____/____	____/____/____	____/____/____
Dependent Social Security <input type="checkbox"/> Child(ren) <input type="checkbox"/> Spouse	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____	per _____	____/____/____	____/____/____	____/____/____
Workers' Compensation	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____	per _____	____/____/____	____/____/____	____/____/____
Company Pension	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____	per _____	____/____/____	____/____/____	____/____/____
Unemployment Compensation	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____	per _____	____/____/____	____/____/____	____/____/____
State Cash Sickness Plan (SDI, TDB, DBL, TDI)	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____	per _____	____/____/____	____/____/____	____/____/____
Other disability income benefit (Federal, State, VA, Individual Disability Insurance, Auto No Fault)	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____	per _____	____/____/____	____/____/____	____/____/____

List Birth Dates of children under 21 years of age.

State law, in some states, requires the following statement: A person commits a fraudulent insurance act, which is a crime, if he or she knowingly and with intent to defraud any insurance company or other person, either: (1) Files a statement of Claim that contains any materially false information; or (2) Conceals for the purpose of misleading, information about any fact that is material to a claim. **VIOLATIONS ARE SUBJECT TO CRIMINAL PROSECUTION AND MAY ALSO RESULT IN SUBSTANTIAL CIVIL PENALTIES.**

AUTHORIZATION TO OBTAIN AND REDISCLOSE INFORMATION

I hereby authorize any hospital, physician, pharmacy or other person, or any health care provider, Insurance Company, Plan Administrator, any Government Agency, Social Security Administration, any information gathering services such as MIB, Inc, or HCI to disclose or furnish to GE Group Life Assurance Company or its representatives, any and all information with respect to any injury or illness including mental illness, drug/alcohol abuse, HIV-related, AIDS or AIDS related information to the extent permitted by law, medical history, consultations, prescriptions, treatments or benefits and copies of all applicable records that may be requested. I also authorize my employer to disclose all information needed to evaluate my claim. A photographic copy of this authorization shall be considered as effective and as valid as the original. This authorization is valid for the duration of the claim.

Date

Claimant's Signature

Phone Number

()

Address (No., Street, City, State, Zip Code)

**ATTENDING PHYSICIAN'S SUPPLEMENTAL STATEMENT
ACCIDENT OR SICKNESS**

Please Answer All Questions

1. DIAGNOSIS (including any complications) _____ ICD-9 Code _____

(a) Objective findings (including current x-rays, EKG, laboratory data and any clinical findings). _____

(b) Subjective symptoms _____

(c) Has patient been hospital confined? Yes No

If yes, give name/address of hospital _____

Confined from _____ through _____

2. DATES OF TREATMENT

(a) Date of last visit Mo. _____ Day _____ Year _____

(b) Frequency Weekly Monthly Other (Specify) _____

3. NATURE OF TREATMENT (Including surgery and medications prescribed, if any).

4. PROGRESS

(a) Has patient reached Maximum Medical Improvement? Yes No

If no, when do you expect a fundamental change? Mo. _____ Day _____ Year _____

(b) When will patient recover sufficiently to return to work? Mo. _____ Day _____ Year _____

(c) Is patient a suitable candidate for further rehabilitation services? Yes No

If yes, circle applicable services: Medical; Psychological; or Vocational

5. CARDIAC (If applicable)

(a) Functional capacity (American Heart Association) Class 1 (No limitation) Class 2 (Slight limitation)
 Class 3 (Marked limitation) Class 4 (Complete limitation)

(b) Blood Pressure (last visit) systolic/diastolic _____/_____

6. FUNCTIONAL LIMITATIONS - ABILITIES

Indicate longest single time duration each activity can be performed.

Indicate frequency per day the listed activity can be performed.

(n - never, o - occasional, f - frequent, c - constant)

LIFTING

CARRYING

_____ 1-5 lbs.	_____ 1-5 lbs.
_____ 6-10 lbs.	_____ 6-10 lbs.
_____ 11-25 lbs.	_____ 11-25 lbs.
_____ 26-50 lbs.	_____ 26-50 lbs.
_____ 51-100 lbs.	_____ 51-100 lbs.
_____ over 100 lbs.	_____ over 100 lbs.

_____ Sitting	_____ Kneeling	_____ R Finger Dexterity
_____ Total time on feet	_____ L	_____ R Below Shoulders
_____ Standing	_____ Inside	_____ L
_____ Walking	_____ Bending	_____ Outside
_____ Bending	_____ Outside	_____ R Above Shoulders
_____ Squatting	_____ Working with Others	_____ L
_____ Stopping	_____ Other (explain) _____	

} Reaching

Doctor: Please describe fully how patient's symptoms/limitations affect ability to work, e.g. how are work schedule or duties restricted and why?

7. PSYCHIATRIC IMPAIRMENT (if applicable)

(a) Please define "stress" 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, personal and social adjustment (severe limitations)

8. Doctor: Please include copies of office notes for the period of treatment, test results, available discharge summaries and any consulting physician reports.

Name of Attending Physician (Please Print)	Degree	Telephone	Fax
Street Address	City or Town	State or Province	Zip Code
Signature	Date	Taxpayer ID Number (EIN)	