



# Attending Physician's Statement

GE Financial  
Employer Services Group

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

This form may be printed  
and faxed to:  
1 (860) 737-7949

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

Name of Patient (Last, First, M.I.) - Please Print	Date of Birth / /
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Diagnosis	ICD - 9 Code
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Symptoms
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Date of First Treatment for this Disability	Date of Most Recent Treatment	Frequency of Treatment <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other _____	Date of Next Appointment
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Disability is Due To  
 Sickness  Accident/Injury If accident, explain how, when & where it occurred.

Is the disability due to injury or sickness caused by patient's current or prior employment?  Yes  No

Is the patient competent to endorse checks and direct the use of the proceeds thereof?  Yes  No

If disability is due to pregnancy, please provide the following  
 L.M.P.: \_\_\_\_\_ Expected Date of Delivery \_\_\_\_\_ Actual Date of Delivery \_\_\_\_\_ Type:  Normal  C-Section

Name of Surgical or Obstetrical Procedure (Describe fully, and provide dates if any)

If any of the following questions are answered "Yes", then please provide the information to the right of that question.

Was the patient treated in an emergency room? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date Treated in Emergency Room / /	Hospital	Physician
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Was the patient treated by another physician? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date Treated By Another Physician	Physician
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Was the patient hospital confined? <input type="checkbox"/> Yes <input type="checkbox"/> No	Dates Confined in Hospital From / / To / /	Hospital
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Did patient have outpatient surgery in a hospital or ambulatory surgical center? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Surgery / /	Name of Facility
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<b>Physical Impairment</b>	<input type="checkbox"/> Class 1 - No Limitation of functional capacity, capable of heavy work. No restrictions.	<input type="checkbox"/> Class 4 - Moderate limitation of functional capacity, capable of clerical/administrative (sedentary) activity.
	<input type="checkbox"/> Class 2 - Medium manual activity.	<input type="checkbox"/> Class 5 - Severe limitation of functional capacity, incapable of minimum (sedentary) activity.
	<input type="checkbox"/> Class 3 - Slight limitation of functional capacity, capable of light work.	

<b>Cardiac</b>	Functional Capacity (American Heart Association)
	<input type="checkbox"/> Class 1 - No Limitation <input type="checkbox"/> Class 2 - Slight limitation <input type="checkbox"/> Class 3 - Marked limitation <input type="checkbox"/> Class 4 - Complete limitation

**Functional Limitations - Abilities**

Indicate frequency per day the listed activity can be preformed. (N - Never, O - Occasional, F - Frequent, C - Constant)	Indicate longest single time duration each activity can be preformed.
<b>LIFTING</b> _____ 1-5 lbs. _____ 6-10 lbs. _____ 11-25 lbs. _____ 26-50 lbs. _____ 51-100 lbs. _____ Over 100 lbs.	<b>CARRYING</b> _____ 1-5 lbs. _____ 6-10 lbs. _____ 11-25 lbs. _____ 26-50 lbs. _____ 51-100 lbs. _____ Over 100 lbs.
	_____ Sitting _____ Total time on feet _____ Standing _____ Walking _____ Bending _____ Squatting _____ Stooing
	_____ Kneeling _____ Inside _____ Outside _____ Working with Others _____ Other (explain) _____
	_____ R Finger Dexterity _____ L _____ R Below Shoulders _____ L _____ R Above Shoulders _____ L

<b>Psychiatric Impairment (if applicable)</b>	<input type="checkbox"/> Class 1 - Patient is able to function under stress and engage in interpersonal relations (no limitations).
	<input type="checkbox"/> Class 2 - Patient is able to function in most stress situations and engage in most interpersonal relations (slight limitations).
	<input type="checkbox"/> Class 3 - Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations (moderate limitations).
	<input type="checkbox"/> Class 4 - Patient is unable to engage in stress situations or engage in interpersonal relations (marked limitations).
	<input type="checkbox"/> Class 5 - Patient has significant loss of psychological, physiological, personal and social adjustment (severe limitations).

The patient has been continuously disabled (unable to work) from \_\_\_\_\_ to \_\_\_\_\_

The patient should be able to work  full-time  part-time on (date) \_\_\_\_\_ or in  1 mth  1-3 mths  3-6 mths  Other \_\_\_\_\_

Remarks

Name of Attending Physician - Please Print	Tax Identification Number
Address (No. Street, City, State, ZIP Code)	Telephone Number ( )
Signature of Attending Physician	Date Signed

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I hereby authorize any physician, medical practitioner, hospital, clinic, pharmacy or other medically related facility or provider of medical services, and any employer, group policyholder, contract holder, insurer or government agency to release to GE Group Life Assurance Company or its representatives, any and all information you may have about my mental and physical history, prescriptions, care and treatment (including drug and/or alcohol abuse information), employment information and insurance coverage or benefit information.

I understand that the information released under this authorization will be used for the purpose of evaluating a claim for benefits.

I agree that this authorization shall be valid for the duration of my claim or the time period permitted by jurisdictional law.

A photocopy of this authorization shall be as valid as the original. I know that I have a right to request and receive a copy of this authorization.

Signature \_\_\_\_\_

Date Signed \_\_\_\_\_

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