Prudential Financial

Group Disability Insurance
Attending Physician's Statement

1 To Be Completed By Employee

Employer/Association Name _____ *Control Number* _____

Employee First Name _____ MI _____ *Social Security Number* ___ - ___ - ____

Employee Last Name _____ Suffix _____

Employee Address - Line 1 _____ Birth date (MM/DD/Year) __ / __ / ____

Employee Address - Line 2 _____ Gender ☐ Male ☐ Female

City _____ State _____ Zip Code _____ - _____

Occupation _____

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

X _____ __ / __ / ____

Employee Signature Date Signed

2 To Be Completed By Attending Physician

Clinical Diagnosis ICD-9 Code Pregnancy EDC

Primary: _____ ___ . __ __ / __ / ____

Secondary: _____ ___ . __

Secondary: _____ ___ . __

Relevant test procedures performed (Please provide results) _____

Surgical procedure(s) performed (Please be specific): Date of Procedure: __ / __ / ____

Current Medications: _____

For Internal Use Only

Claim Number _____

* 1 0 3 A 0 1 *

The Prudential Insurance Company of America
Disability Management Services
PO Box 13480, Philadelphia, PA 19101
Tel: 1-800-842-1718 Fax: 1-877-889-4885

Prudential Financial

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Employee Last Name

Social Security Number

2 Attending Physician Information (Cont'd)

Was Claimant hospital confined? ☐ Yes ☐ No

If Yes, please provide name and address of hospital:

If hospitalized, give dates:
From: / /
To: / /

Other Treating Physicians or Consultants

Physician Name	Specialty	Phone 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: / /

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

Prognosis for Return to Function / Return to Work:

Return to Work Plan (Please describe): Target Date: / /

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Employee Last Name _____ Social Security Number ___ - ___ - ____

2 Attending Physician Information (Cont'd)

Describe Medical Obstacles to Return to Work: _____

Are there any Non-Medical Factors which 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 ☐☐ / ☐☐ / ☐☐☐☐

Last Visit ☐☐ / ☐☐ / ☐☐☐☐

Frequency of Visits: _____

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

☐ Sedentary	☐ Light	☐ Medium	☐ Heavy	☐ Very Heavy	☐ Other
Negligible Weight Mostly Sitting	Up to 10 lbs. frequently Up to 20 lbs. occasionally and / or Frequent Walk/Stand and / or Constant Push/Pull	10 to 25 lbs. freq. Up to 50 lbs. occ.	25 to 50 lbs. freq. 50 to 100 lbs. occ.	More than 50 lbs. freq. 100 lbs. occasionally	(Please describe below)

_____

_____

3 Physician Information

Physician Name _____ Primary Phone Number ___ - ___ - ____

Office Address _____ Fax Number ___ - ___ - ____

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.

X _____ ☐☐ / ☐☐ / ☐☐☐☐

Physician Signature — Date Completed