DISABILITY CLAIM FORM
The Benefits Center
P.O. Box 100158, Columbia, SC 29202-3158
Toll-free: 1-866-229-4885 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

PART II: TO BE COMPLETED BY PHYSICIAN OR TREATING PROVIDER

Instructions: Please complete, sign and date this form. The purpose of this form is to assist us in making a disability determination. Please complete all questions on this form and provide copies of supporting reports, such as office notes, medical records, medication logs, consultations and/or testing. Please note: Medical records containing genetic information, including family history, should not be released to Unum. Please be sure to sign and date this form in Section F.

A. Patient Information

Height: | Weight: | Date of first visit regarding current condition(s) (mm/dd/yy):

Did you advise the patient to stop working? ☐ Yes ☐ No | If yes, what was the first date the patient was unable to work (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: From (mm/dd/yy) Through (mm/dd/yy)

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

B. Diagnosis

What is the primary diagnosis preventing the patient from working?

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

DSM-IV: I | II | III | IV | V

What are the other conditions that prevent the patient from working? ☐ NA

Secondary Diagnosis: | ICD:

Secondary Diagnosis: | ICD:

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?

C. Treatment

Describe the patient's current treatment program:

Medications (please include the medication log)

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ATTENDING PHYSICIAN STATEMENT (Continued)

Patient's Name | Date of Brith (mm/dd/yy)

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

Was surgery performed? ☐ Yes ☐ No | If yes, name of surgical procedure: | CPT-4 code: | Date surgery performed (mm/dd/yy):

Is the patient still under your care? ☐ Yes ☐ No | If no, final date of treatment (mm/dd/yy):

D. Other Treating Providers or Hospitals

Please provide complete name, contact information and specialty of any other treating physicians or hospitals.

Name	Specialty	Address	Telephone Number

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

Patient's ability to: *(Please check all that apply)*

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

Patient's ability to perform: *(Please check all that apply)*

	Never 0%		Occasionally 1-33%		Frequently 34-66%		Continuously 67-100%		Unknown	
	R	L	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 all that apply)*

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

Patient's ability to lift/carry: *(Please check all that apply)*

	Never 0%	Occasionally 1-33%	Frequently 34-66%	Continuously 67-100%	Unknown
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 | Date of Birth (mm/dd/yy)

Please indicate restrictions (activities the patient should not do) and limitations (activities the patient cannot do) in the space provided below.

RESTRICTIONS:

LIMITATIONS:

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.

F. 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	