

# Attending Physician's Statement of Impairment and Function

ING Employee Benefits  
P.O. Box 1290 • Minneapolis, MN 55440-1290  
1-800-328-4090



## EMPLOYEE BENEFITS

- ReliaStar Life Insurance Company of New York (outside NY)  
 ReliaStar Life Insurance Company

*The patient is responsible for the completion of this form without expense to the Company.*

Patient Name (Please print)		Claim #	Group #	
Date of Birth / /		Sex	Social Security Number	
Patient's Full Home Address (P.O. Box Number or Street, City, State, Zip)				

### DIAGNOSIS and TREATMENT INFORMATION

Primary Diagnosis	List All Additional Diagnoses in Order of Severity 1. 2. 3.	
Subjective Symptoms	Objective Findings Supported by Testing	
Diagnostic Tests Performed (include dates and results)		
Procedure(s)		
Date you first saw your patient for this condition.	Date you advised your patient to cease working due to this condition.	Date you last saw your patient for this condition.
Is this condition due to an accident? If yes, is it work-related?	Has your patient ever had the same or similar condition?	Has your patient been hospitalized for this condition? If yes, when? From: To: Where?

### CURRENT PLAN of TREATMENT

Frequency of current visits: <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other <i>Specify:</i> _____	Medications (include name and dosage)
Therapy Prescribed: <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Speech Therapy <i>Frequency:</i> _____	
Is patient compliant with therapy? Yes <input type="checkbox"/> No <input type="checkbox"/>	Tolerance to therapy: Good <input type="checkbox"/> Poor <input type="checkbox"/>

### COMPETENCY

**Do you believe that this patient is competent to endorse checks and direct the use of proceeds thereof? Yes  No**

### PHYSICIAN REFERRAL INFORMATION

Have you referred this patient to another Physician? Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, please provide the name and address of that Physician:
Did another Physician refer this patient to you? Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, please provide the name and address of that Physician:

### SUSTAINED TOLERANCE TO:

**(Please circle appropriate section.)**

<i>Indicate what accommodations would increase tolerance to any of these sections:</i>	Sit	None	< 1 Hour	1-2 Hours	3-4 Hours	5-6 Hours	7-8 Hours
	Stand	None	< 1 Hour	1-2 Hours	3-4 Hours	5-6 Hours	7-8 Hours
	Walk	None	< 1 Hour	1-2 Hours	3-4 Hours	5-6 Hours	7-8 Hours

Patient's Name: \_\_\_\_\_

**PATIENT CAN LIFT/CARRY: (Please check appropriate box for each weight range.)**

Maximum Pounds	Less Than 10 Pounds	10–19 Pounds	20–49 Pounds	50–99 Pounds	100 or More Pounds
Never					
Occasionally (0–2.5 hrs/day)					
Frequently (2.5–5.5 hrs/day)					
Continuously (5.5+ hrs/day)					

**PATIENT CAN USE UPPER EXTREMITIES FOR REPETITIVE TASKS:**

	Simple Grasping	Pushing / Pulling	Fine Manipulation
Right Hand	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Left Hand	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Both Hands	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

**PATIENT CAN USE LOWER EXTREMITIES FOR REPETITIVE MOVEMENTS: (ie. Foot Controls)**

Both Feet	<input type="checkbox"/> Yes <input type="checkbox"/> No	Right Foot	<input type="checkbox"/> Yes <input type="checkbox"/> No	Left Foot	<input type="checkbox"/> Yes <input type="checkbox"/> No
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**PATIENT IS ABLE TO: (Please check appropriate column.)**

	Climb	Balance	Stoop	Kneel	Crouch	Crawl	Reach (above shoulders)	Handle	Finger	Feel
Not At All										
Occasionally (0–2.5 hrs/day)										
Frequently (2.5–5.5 hrs/day)										
Continuously (5.5+ hrs/day)										

**CARDIAC FUNCTIONAL CAPACITY: (if applicable) American Heart Association**

Class 1 <input type="checkbox"/> (No Limitation)	Class 2 <input type="checkbox"/> (Slight Limitation)	Class 3 <input type="checkbox"/> (Marked Limitation)	Class 4 <input type="checkbox"/> (Complete Limitation)
Height ft. in.	Weight lbs.	Blood Pressure	Date of Reading

**ESTIMATED RETURN TO WORK INFORMATION:**

Part Time Date: _____ # of hours per week: _____ With These Physical Limitations:	Full Time Date: _____ With These Physical Limitations:
NO Physical Limitations: Part Time Date: _____ # of Hours Per Week: _____	NO Physical Limitations: Full Time Date: _____
Has this patient reached Maximum Medical Improvement? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, anticipated date of MMI: _____ Additional Comments:	

**PHYSICIAN INFORMATION:**

Attending Physician Name: (please print)	Board Certification:	
Mailing Address:	Phone:	Fax:
City:	State:	Zip Code:

Physician's Signature: \_\_\_\_\_ Specialty: \_\_\_\_\_ Date: \_\_\_\_\_

# Fraud Warnings

## **STANDARD:**

Any person who knowingly and with intent to defraud, submits an application or files a claim containing any materially false or misleading information, commits a fraudulent act, which is a crime.

## **In CALIFORNIA:**

For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

## **In COLORADO:**

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

## **In DISTRICT of COLUMBIA:**

It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

## **In FLORIDA:**

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

## **In LOUISIANA:**

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

## **In NEW JERSEY:**

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

## **In OREGON:**

Any person who knowingly and with intent to defraud submits an application or files a statement of claim containing any materially false or misleading information, may be guilty of insurance fraud.

## **In PENNSYLVANIA:**

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.