

Section I — Attending Physician's Statement

Patient name: _____

Date of birth: _____

(MM-DD-YYYY)

Disability

1. Diagnosis of condition causing disability, indicate degree of severity: _____ ICD-9 Code _____

2. Prognosis (estimate in months or years): _____

3. Is the dependent **incapable** of self-support by reason of mental or physical disability? Yes No

4. Is the dependent now confined to an institution? Yes No

If yes, name of institution:

Address: _____

Phone # _____

Please print clearly. A signature is required before the application can be processed.

Physician's full name _____ Specialty _____

Full address _____

(PO Box and Street, City, State and Zip)

Phone no. () _____ Fax no. () _____

Physician sign here *X* _____ Date signed _____

— Warning —

Any person who knowingly and with intent to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony. Report fraud to our Fraud Hotline (800) 530-5989.