New York Life Insurance Company
Individual Disability Insurance
1500 Main Street, Suite 1400, P.O. Box 15189
Springfield, MA 01115-5189

Physician's Statement for New Claim - Individual Disability Insurance

STEP 1 Insured's information *To be completed by Insured/patient*

Name			Occupation
FIRST	MIDDLE	LAST	

Policy number(s)	Claim number(s)

Date of birth MM/DD/YYYY	Height	Weight	Last 4 digits of Social Security number

STEP 2 Disability Information

Disability Information: Information should be based on your medical opinion which may include supporting findings such as x-rays, EKGs, laboratory data/testing, clinical testing and/or any other relevant information.

A. Diagnosis impacting function: | Diagnosis code:

Symptoms:

Onset date of symptom(s)

Nature of treatment:

Medications prescribed and dosage/frequency:

Pharmacy name and phone number:

Complete B and C below if more than one diagnosis. Use additional paper if needed.

B. Diagnosis impacting function: | Diagnosis code:

Symptoms:

Onset date of symptom(s)

Nature of treatment:

Medications prescribed and dosage/frequency:

Pharmacy name and phone number:

C. Diagnosis impacting function: | Diagnosis code:

Symptoms:

Onset date of symptom(s)

Nature of treatment:

Medications prescribed and dosage/frequency:

Pharmacy name and phone number:

D. Current patient status: ☐ Ambulatory ☐ Confined to home ☐ Confined to bed ☐ Confined to hospital

E. Is the patient currently able to drive? ☐ Yes ☐ No

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STEP 3 History

Was patient referred to you by **another** practitioner? ☐ Yes ☐ No

Did you advise the patient to stop working due to medical condition? ☐ Yes ☐ No If yes, provide date advised:

If no, please explain:

Patient progress since onset of medical condition: ☐ Recovered ☐ Improved ☐ Unchanged

Has the patient been released from your care? ☐ Yes ☐ No If yes, please provide date released: MM/DD/YYYY

Has patient been hospitalized? ☐ Yes ☐ No If yes, please provide dates hospitalized MM/DD/YYYY FROM TO

Date of first visit: MM/DD/YYYY	Date of last visit: MM/DD/YYYY	Date of next visit: MM/DD/YYYY	Frequency of visits: ☐ Weekly ☐ Monthly ☐ Other

Hospital name:	Reason for hospitalization/surgical procedures:

Hospital address:

STREET CITY STATE ZIP

Did you refer the patient to any other practitioner(s)? ☐ Yes ☐ No If yes, please provide name(s) and address(es) of practitioners:

STEP 4 Rehabilitation and Return to Work

Has the patient been medically cleared to return to work? ☐ Yes ☐ No Expected/actual return date: MM/DD/YYYY

Are there job modifications/accommodations that might allow Insured to return to work? ☐ Yes ☐ No

If yes, please explain:

Is the patient currently receiving any rehabilitation treatment? ☐ Yes ☐ No

If yes, please provide dates of rehabilitation treatment: MM/DD/YYYY FROM TO

Nature of rehabilitation:

Rehabilitation provider/
facility name and address:

Is the patient motivated to return to their usual work or any other work for which they are qualified? ☐ Yes ☐ No

Please explain:

Has the patient's medical condition improved to its maximum level? ☐ Yes ☐ No

Please explain:

STEP 5 Functional Capacity Limitations/Restrictions

On what basis did you assess the patient's functional capacity?
☐ Observed activity ☐ Measured capacity ☐ Patient self disclosure ☐ Other, please explain

What duties can the patient currently **not** perform due to their medical condition?

How often is the patient able to perform the following activities in a typical eight-hour workday?

	Frequently (4-8)	*Occasionally (2-4)*	*Seldom (1-2)*	*Never*
Sitting	☐	☐	☐	☐
Standing	☐	☐	☐	☐
Walking	☐	☐	☐	☐
Driving	☐	☐	☐	☐
Bending / Twisting (at waist)	☐	☐	☐	☐
Bending / Twisting (at neck)	☐	☐	☐	☐
Squatting / Crawling / Climbing	☐	☐	☐	☐
Reaching (above / below shoulder)	☐	☐	☐	☐
Using computer	☐	☐	☐	☐

What is the estimated maximum weight that the patient is currently able to lift/carry? lbs

Which is the patient's dominant hand? ***Circle one:*** Right Left

What is the patient's current ability to manipulate each hand? ***Check all that apply.***

Right: ____ Simple grasping ____ Fine manipulation **Left:** ____ Simple grasping ____ Fine manipulation

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STEP 5 Functional Capacity Limitations/Restrictions CONTINUED FROM PREVIOUS PAGE

Based on your assessment, please answer the below questions related to the patient's current level of impairment/limitations:

PHYSICAL IMPAIRMENT *(as defined in Federal Dictionary of Occupational Titles)*

- ☐ Class 1: No limits of functional capacity, capable of heavy work. No restrictions (0–10%)
- ☐ Class 2: Medium manual activity (15–30%)
- ☐ Class 3: Slight limitations of functional capacity, capable of light work (35–55%)
- ☐ Class 4: Moderate limitations of functional capacity, capable of clerical/administrative (sedentary) activity (60–70%)
- ☐ Class 5: Severe limitations of functional capacity, incapable of minimal (sedentary) activity (75–100%)

CARDIAC IMPAIRMENTS *(Based on New York Heart Association Functional Classifications)*

PATIENT SYMPTOMS

- ☐ Class I: No limitation of physical activity. Ordinary physical activity does not cause undue fatigue, palpitation, dyspnea.
- ☐ Class II: Slight limitation of physical activity. Comfortable at rest. Ordinary physical activity results in fatigue, palpitation, dyspnea.
- ☐ Class III: Marked limitation of physical activity. Comfortable at rest. Less than ordinary activity causes fatigue, palpitation, or dyspnea.
- ☐ Class IV: Unable to carry on any physical activity without discomfort. Symptoms of heart failure at rest. If any physical activity is undertaken, discomfort increases.

OBJECTIVE ASSESSMENT

- ☐ Class A: No objective evidence of cardiovascular disease. No symptoms and no limitation in ordinary physical activity.
- ☐ Class B: Objective evidence of minimal cardiovascular disease. Mild symptoms and slight limitation during ordinary activity. Comfortable at rest.
- ☐ Class C: Objective evidence of moderately severe cardiovascular disease. Marked limitation in activity due to symptoms, even during less-than-ordinary activity. Comfortable only at rest.
- ☐ Class D: Objective evidence of severe cardiovascular disease. Severe limitations. Experiences symptoms even while at rest.

STEP 6 Visual Capacity Limitations/Restrictions

On what basis did you assess the patient's visual capacity? ☐ Not applicable

☐ Observed activity ☐ Measured capacity ☐ Patient self disclosure ☐ Other, please explain

What was the patient's level of visual capacity when last observed (Snellen Notation):

How could the patient's vision : be restored in whole or in part?					
	O.D.	☐ Lenses	☐ Treatment	☐ Operation	☐ Not restorable
	O.S.	☐ Lenses	☐ Treatment	☐ Operation	☐ Not restorable

Date of most recent visual acuity exam: MM/DD/YYYY

What duties can the patient currently **not** perform due to visual limitations?

STEP 7 Mental Capacity Limitations/Restrictions

On what basis did you assess the patient's mental capacity? ☐ Not applicable

☐ Observed activity ☐ Measured capacity ☐ Patient self disclosure ☐ Other, please explain

MENTAL HEALTH QUESTIONNAIRE: Based on your assessment of the patient, please circle the word that best describes their level of functioning using the definitions listed below and assuming that these activities must be performed on a regular and sustained basis.

None: There are no limitations on the ability to function in this area.
Mild: There are limitations on ability to function but they are mild or transient.
Moderate: The ability to function in this area is less than marked but more than mild.
Marked: The ability to function in this area is seriously limited.
Extreme: The ability to function in this area is precluded.
Not Ratable: There is no evidence available to rate the ability to function in this area.

Ability to interact appropriately with the general public.

None Mild Moderate Marked Extreme Not Ratable

Ability to understand and remember very short and simple instructions.

None Mild Moderate Marked Extreme Not Ratable

Ability to understand and remember detailed instructions.

None Mild Moderate Marked Extreme Not Ratable

Ability to maintain attention and concentration for extended periods of time.

None Mild Moderate Marked Extreme Not Ratable

Ability to complete a task without interruptions from psychologically based symptoms and to perform at a consistent pace.

None Mild Moderate Marked Extreme Not Ratable

Your signature is required on the next page ▶

STEP 7 Mental Capacity Limitations/Restrictions CONTINUED FROM PREVIOUS PAGE

MENTAL/NERVOUS IMPAIRMENT

- ☐ Class 1: Patient is able to function under stress and engage in interpersonal relations. (No Limits)
- ☐ Class 2: Patient is able to function in most stress situations and engage in most interpersonal relations. (Slight Limits)
- ☐ Class 3: Patient is able to function in only limited situations and engage in limited interpersonal relations. (Moderate Limits)
- ☐ Class 4: Patient is unable to engage in stress situations or engage in interpersonal relations. (Marked Limits)
- ☐ Class 5: Patient has significant loss of psychological, personal and social adjustments. (Severe Limits)

What duties can the patient currently **not** perform due to mental/nervous impairment?

Is the patient competent to manage their property unassisted, and to understand the nature and consequence of their action(s), including the ability to endorse checks and direct use of the proceeds? ☐ Yes ☐ No

Was psychological or neuropsychological testing performed? ☐ Yes ☐ No If yes, what date(s)? MM/DD/YYYY

If yes, what type of testing and what were the results? ***Please provide a copy of test results with this form.***

Has a Guardian been appointed or is a POA in place? ☐ Yes ☐ No ☐ Unknown
If yes, provide the specific Guardian/POA name:

STEP 8 Based on on objective findings and your medical opinion

A. The patient was unable to work MM/DD/YYYY FROM TO

B. The patient was able to perform some work MM/DD/YYYY FROM TO

List all current restrictions and limitations you have placed on the patient's work and personal activities due to his or her medical condition. If none, indicate "NONE". Use additional paper as needed.

STEP 9 Additional Information

Please provide any additional comments relevant to the patient's medical condition:

STEP 10 Attending Physician's Declaration and Signature

Attending physician name FIRST MIDDLE LAST | Specialty/ Degree

Address STREET CITY STATE ZIP | License Number

Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. Please refer to the enclosed page entitled STATE VARIATIONS OF FRAUD WARNINGS enclosure for specific notices required in certain jurisdictions.

I declare that the answers on this statement are true to the best of my knowledge and belief. I understand that periodic update (including providing a copy of medical records when requested) will be required in the event of continuing claim.

X

Date | Physician's Signature

Please affix stamp or seal here

☐☐☐ – ☐☐☐ – ☐☐☐☐
Telephone

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Fax

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Tax ID

If we need more information, who is the best person at your office to contact?

STEP 11 Done! Send us your completed form.

Mail: **New York Life, Individual Disability Insurance, 1500 Main Street, Suite 1400, P.O. Box 15189, Springfield, MA 01115-5189**

Fax: **1-(833) 963-3462** Email: **IDIClaims@IDI.newyorklife.com** Questions? Call us at (844)-420-1391