



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 Continuing Claim – Individual Disability Insurance

STEP 1 Patient information *To be completed by New York Life*

Name		Date of birth	
FIRST	MIDDLE	LAST	MM/DD/YYYY
Policy number(s)		Claim number(s)	

STEP 2 Attending Physician's Statement *To be completed and signed by Attending Physician*

Section 1. Condition Update

Primary Diagnosis:	Diagnosis code:
Secondary Diagnosis:	Diagnosis code:
Other conditions:	
When did symptoms first appear? MM/DD/YYYY	If applicable, what was accident date? MM/DD/YYYY
Has the patient ever had same/similar condition? ☐ Yes ☐ No	If yes, when? MM/DD/YYYY

Section 2. Treatment Update

First consultation MM/DD/YYYY	Most recent consultation MM/DD/YYYY	Next scheduled consultation MM/DD/YYYY	Released MM/DD/YYYY
Is / Was Surgical / Medical Procedure Required? ☐ Yes ☐ No	If yes, when? MM/DD/YYYY		Facility location:
Is / Was Hospitalization Required? ☐ Yes ☐ No	If yes, admission date MM/DD/YYYY	Discharge MM/DD/YYYY	Facility location:

Please summarize current treatment plan:

Section 3. Restrictions & Limitations

Patient **has the ability** to work in the following capacity: ☐ No work ☐ Sedentary ☐ Light ☐ Medium ☐ Heavy ☐ Full capacity

Patient **is currently unable** to work because of an inability to: *(Please check all that apply)*

☐ Sit	☐ Stand	☐ Walk	☐ Lift	☐ Carry	☐ Drive
☐ Reach	☐ Kneel	☐ Squat	☐ Climb	☐ Crawl	

Time limit:

Weight limit:

Please provide a summary of the patient's specific restrictions and limitations:

What objective clinical / diagnostic findings support these Restrictions and Limitations?

STEP 2 Attending Physician's Statement *Continued from previous page*

What is the estimated recovery period for the patient? MM/DD/YYYY

Are the current restrictions and limitations permanent? ☐ Yes ☐ No

The patient was unable to work

FROM
MM/DD/YYYYTO
MM/DD/YYYY

The patient was able to perform some work

FROM
MM/DD/YYYYTO
MM/DD/YYYY**STEP 3 Attending Physician's Declaration and Signature**

Attending physician name

Specialty/ Degree

FIRST

MIDDLE

LAST

Address

Phone number

STREET

CITY

STATE

ZIP

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

STEP 4 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