Life & Annuity Insurance Company

ADA Life and Disability
P.O. Box 1700
Denver, CO 80201
1-800-537-2033

WAIVER OF PREMIUM – Plan 104GP
Attending Physician's Statement

NOTE: Great West Life & Annuity Insurance Company assumes no responsibility for any expense incurred in the completion of this statement.

Name of patient ______________________ Date of birth ____/____/____
Month Day Year

Patient's address ______________________
Number Street City State Zip Code

I hereby authorize release of information requested on this form, by the below named physician for the purpose of claim processing. I understand any information obtained will not be released by Great-West Life & Annuity Insurance Company to any person or organization EXCEPT to reinsuring companies, or the persons or organizations performing business or legal services in connection with my claim.

Signed (Patient) ▶ Date ____/____/____

1. History

(a) When did symptoms first appear or accident happen?................................. Mo. ______ Day ______ 20 ______
(b) Date patient ceased work because of disability... Mo. ______ Day ______ 20 ______
(c) Has patient ever had same or similar condition?... ☐ Yes ☐ No If "Yes" state when & describe in Remarks.
(d) Is condition due to injury or sickness arising out of patient's employment? ☐ Yes ☐ No ☐ Unknown
(e) If condition due to automobile accident, indicate state in which it occurred ______________________
(f) Names and addresses of other treating physicians

2. Diagnosis (including any complications)

(a) Date of last examination.. Mo. ______ Day ______ 20 ______
(b) Diagnosis (including any complications)
(c) If disability due to pregnancy what is expected/was delivery date............... Mo. ______ Day ______ 20 ______
(d) Please describe any complications that would extend this disability longer than for a normal pregnancy.
(e) Subjective symptoms
(f) Objective findings (including current X-rays, EKG's, Laboratory Data and any clinical findings)

3. Dates of Treatment

(a) Date of first visit.. Mo. ______ Day ______ 20 ______
(b) Date of last visit... Mo. ______ Day ______ 20 ______
(c) Frequency... ☐ Weekly ☐ Monthly ☐ Other (specify)

4. Nature of Treatment (including surgery and medications prescribed, if any)

5. Progress

(a) Has patient.. ☐ Recovered? ☐ Improved? ☐ Remained unchanged? ☐ Retrogressed?
(b) Is patient... ☐ Ambulatory? ☐ House confined? ☐ Bed confined? ☐ Hospital confined?
(c) Has patient been hospital confined................................... ☐ Yes ☐ No If "Yes" give name and address of hospital
______________________ Confined from ______________ Through ______________

6. Cardiac (if applicable)

(a) Functional capacity............................... ☐ Class 1 (No limitation) ☐ Class 2 (Sight limitation)
(American Heart Association) ☐ Class 3 (Marked limitation) ☐ Class 4 (Complete limitation)
(b) Blood pressure (last visit).................... Systolic ______________ /Diastolic ______________

7. Physical Impairment (*as defined in US Dept of Labor Dictionary of Occupations Titles) Please offer your recommendations

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

8. Mental/Nervous Impairment (if applicable)

What stress and problems in interpersonal relations has claimant had on job?

- ☐ Class 1 - Patient is able to function under stress and engage in interpersonal relations (no limitations)
- ☐ Class 2 - Patient is able to function in most stress situations and engage in most interpersonal relations (slight limitations)
- ☐ Class 3 - Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations (moderate limitations)
- ☐ Class 4 - Patient is unable to engage in stress situations or engage in interpersonal relations (marked limitations)
- ☐ Class 5 - Patient has significant loss of psychological, physiological, personal and social adjustment (severe limitations)

9. Do you believe the patient is competent to handle personal business matters? ☐ **Yes** ☐ **No**

10. Prognosis

(a) Has patient made significant progress? ☐ Yes ☐ No

Please explain:

(b) What changes do you expect in the near future?

11. Rehabilitation and return to work.

(a) As of what date do you recommend patient to return to own occupation?

☐ Part-time ________/________/________ ☐ Full-time ________/________/________

(b) As of what date do you recommend patient to return to any other work?

☐ Part-time ________/________/________ ☐ Full-time ________/________/________

(c) Is patient a suitable candidate for occupational rehabilitation? ☐ Yes ☐ No

12. Remarks

Name (attending physician) / **Please Print** ______ Degree / Specialty ______ ( ) Telephone ______

Street Address ______ ( ) Fax ______

City or Town ______ State ______ Zip Code ______

Signature ______ Date ______

Stamp or signature other than physician's own signature will not be accepted.