

**WAIVER OF PREMIUM – Plan 104GP
Attending Physician’s Statement**

NOTE: Great-West 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

Date of Admission: Mo. _____ Day _____ 20 _____ Date of Discharge: Mo. _____ Day _____ 20 _____

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.*