AIG

AIG
Group Benefits

American General Life Insurance Company*
Houston, Texas
The United States Life Insurance Company in the City of New York*
New York, New York
*This company does not solicit business in New York

Attending Physician's Statement
Waiver of Premium Benefit

PO Box 14294, Lexington, KY 40512
Tel +1 800-289-2266 Fax +1 855-864-0530
Email: claimsubmission@groupclaims.com

THE PATIENT IS RESPONSIBLE FOR THE COMPLETION OF THIS FORM WITHOUT EXPENSE TO THE COMPANY.

Name of Patient			Date of Birth
Address	City	State	Zip Code
Employer Name		Policy Number	

HISTORY

When did symptoms first appear or accident happen? ..... Month _____ Day _____ Year _____

Date patient was unable to work because of disability..... Month _____ Day _____ Year _____

Has patient ever had same or similar condition? ☐ Yes ☐ No If "Yes", state when and describe _____

Is condition due to injury or sickness arising out of patient's employment? ..... ☐ Yes ☐ No ☐ Unknown

Names and addresses of other treating physicians

DIAGNOSIS

Diagnosis (including any complications) _____

Subjective symptoms _____

Objective findings (include current X-rays, EKGs, Laboratory Date and any clinical findings) _____

DATES OF TREATMENT

Date of first visit _____ Date of last visit _____ Frequency ☐ Weekly ☐ Monthly ☐ Other (Specify) _____

NATURE OF TREATMENT *(including surgery and medications prescribed, if any)*

PROGRESS

Patient has ..... ☐ Recovered ☐ Improved ☐ Unchanged ☐ Retrogressed

Patient is ..... ☐ Ambulatory ☐ House Confined ☐ Bed Confined ☐ Hospital Confined

HOSPITALIZATION

Has patient has been hospital confined? ☐ Yes ☐ No If Yes, hospital name _____

Address: _____ Confined from _____ through _____

CARDIAC *(if applicable) Functional Capacity (American Heart Association)*

☐ Class 1 (No limitations) ☐ Class 2 (Slight limitation) ☐ Class 3 (Marked limitation) ☐ Class 4 (Complete limitation)

Blood Pressure (last reading) _____ /_____ as of _____ Date

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

☐ 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%)
☐ Remarks _____

MENTAL/NERVOUS IMPAIRMENT *(if applicable)*

List the patient's DSM-IV Axes:
Axis I _____ Axis II _____ Axis III _____ Axis IV _____
List the patient's most recent GAF Score _____ Date of assessment _____ Highest GAF Score in the last year _____
Please fully describe the patient's limitations _____

Do you believe the patient is competent to endorse checks and direct the use of proceeds thereof? ☐ Yes ☐ No

PROGNOSIS

What are the patient's current restrictions and limitations? _____

	PATIENT'S JOB:	**ANY OTHER WORK:**
If none, when was patient able to resume work?	Month_____ Day_____ Year_____	Month_____ Day_____ Year_____
Do you expect a fundamental or marked change in the future including improvement and/or deterioration?	☐ Yes ☐ No	☐ Yes ☐ No
When will patient recover sufficiently to perform duties?	☐ 1 Month ☐ 1-3 Months ☐ 3-6 Months ☐ Indefinitely ☐ Never	☐ 1 Month ☐ 1-3 Months ☐ 3-6 Months ☐ Indefinitely ☐ Never

REHABILITATION

Is patient a suitable candidate for further rehabilitation services?..... ☐ Yes ☐ No Explain under REMARKS.
(i.e., cardiopulmonary program, speech therapy, etc.)
Would job modification enable patient to work with impairment? ..... ☐ Yes ☐ No Explain under REMARKS.
Would vocational counseling and/or retraining be recommended? ..... ☐ Yes ☐ No Explain under REMARKS.

REMARKS

THESE STATEMENTS ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

Name of Physician Completing This Form (Print)	Degree/Specialty	Tax ID Number
Address	City	State	Zip Code
Telephone Number	Fax Number	
Signature		Date