Supplementary Report for Benefits



Section 1 – To be completed by claimant (Please print or type.) Policy/Participation/Account no. - -

1.	Your name 2. A		2. Address (stree	et, city,	3. Date of birth		
4.	Home phone	5. So	cial Security number	6.	Email address	7. Emplo	oyer's name
7.	7. Have you worked since becoming disabled? Yes No If "Yes," on what date: Full- time Part- time 9. Are you receiving benefits from any of the following so			8. Do you expect to return to work? Yes No If "Yes," on what date: Full- time Part- time			
9.	Are you receiving be	ments in	on any or the lollow	Yes	Current Amount	No	If "No," have you made application for this benefit?
	econsideration for these	Disability nt Act sation Commissi stirement nt ove source benefits.	ces have been denie		ard a copy of the denial no		
10.	Yes No If "Yes			you pi	an to receive any addition	ai education	or training?
11. Are you receiving Vocational Rehabilitation?							
12.	Have you discussed re	turning to	work with your docto	or?	☐Yes ☐No	If "Yes," wh	nat did he/she advise?
enfo or m repre Unio as v HIPA Com	rcement agency, educat nental condition, rehabil esentative, any and all s n Security Insurance Co alid as the original. I ag	ional institation and such informany to gree this cessary,	itute, governmental and other non-medical mation. I UNDERS of determine eligibility authorization shall be may be asked to	agency al infor FAND y for be be valid execu	r, or employer having med mation of me to give to the information obtained enefits. I know that a pho of for the duration of the	lical informat Union Secu by use of the tographic co claim. This a	cial Security Administration, law tion with respect to any physical urity Insurance Company, or its is authorization will be used by the py of this authorization shall be tuthorization is not governed by wing Union Security Insurance

After completion of Section 1, please forward the form to Attending Physician for completion of Section 2.

Products and services marketed by Assurant Employee Benefits are underwritten and/or provided by Union Security Insurance Company.

Section 2 – To be completed by Attending Physician (Please print or type.)

2201101	Diagnoses Subjective symptoms							
	Objective findings	ature of ongoing treatment						
History		Date of last visit						
	Has patient been hospital confined since last report? Yes Date(s) of confinement from to Name and address of hospital							
Cardiac	Complete only if applicable. Functional Capacity (American Heart Association) Class 1 (no limitation) Class 2 (slight limitation) Class 3 (marked limitation) Class 4 (complete limitation) Blood pressure (latest reading) as of (date) Is patient in a cardiac rehabilitation program? Yes No							
Physical Impairment	Occasionally lift and/or carry: No more Stand and/or walk a total of: Less the (If marked limitation, describe degree.)	20 lbs.						
Psychiatric Impairment	Complete only if applicable. (a) Check appropriate response: Judgement	☐ Moderately ☐ Severely ☐ No deficits noted ☐ Moderately ☐ Severely ☐ No deficits noted ☐ Moderately ☐ Severely ☐ No deficits noted ☐ Slight ☐ None noted ☐ Thought Disorder ☐ Bizarre ideas ☐ No symptoms noted ☐ Indicate the use of the proceeds thereof? ☐ Yes ☐ No						
Work Capabilities	Please describe fully how patient's symptoms/limitations affect ability to work, e.g. how are work schedule or duties restricted and why. When did these limitations apply? Began Ended							
Prognosis	Prognosis:	☐ Excellent r partial recovery? ☐ No ☐ Unknown ☐ Yes ☐ No If "No," when——— ☐ Unknown						
Return To Work Information	Has the patient been released to return to work at his/her occupation? If "Yes", on what date	? Yes No Part time Full time						
Retu We	Has the patient been released to return to work at any occupation? If "Yes", on what date	☐ Yes ☐ No ☐ Part time ☐ Full time						
Rehab	Is patient a candidate for rehabilitation services? Would job modification enable patient to work with impairment? Would vocational counseling and/or retraining be recommended?	☐ Yes (Describe.) ☐ No (Explain.) ☐ Yes (Describe.) ☐ No ☐ Yes (Elaborate.) ☐ No						
Name	Physician's name Street address Telephone no Signature Date	Degree/Specialty ZIP CODE Fax no DO NOT PRE-DATE PHYSICIAN'S EIN OR SSN						
Patie	nt	Policy/Participation/Account no						