Professional Insurance Co
PO Box 85656, Lincoln, NE 68501
1-800-289-1122

Supplementary Statement of Disability

Must Be Completed in Full at No Expense to Professional Insurance Company

Employee Statement

Claimant's Full Name (Please Print) | Policy number | Claim number

1. Have you returned to any work since you were disabled? ☐ No ☐ Yes Date _____ ☐ Part-time ☐ Full-time

2. Do you expect to return to work in the near future? ☐ No ☐ Yes Approximate date _____ ☐ Part-time ☐ Full-time

3. Have there been any changes in your condition in the past year?
   ☐ Remains the same ☐ Has worsened ☐ Has improved

4. Have there been any changes in your lifestyle? ☐ No ☐ Yes If yes, please explain_____
   _____
   Are you living: ☐ At home ☐ In an assisted living facility (Address)_____
   ☐ In a Convalescent facility (Address) _____

5. Activities of daily living.
   Are you able to ☐ Ambulate without assistance ☐ Leave your home ☐ Drive

6. Are you currently participating in any
   ☐ Part-time work ☐ Volunteer work ☐ Study program ☐ Therapy
   If "yes" to any of the above please explain _____

_____

7. Are you now eligible for, have you applied for, or are you now receiving income from:

	Yes	No	Amount of income	Period (Wk, Bi-Wk or Mo)	Date Application Filed	Date Income Began	Date Income Ended
Primary Social Security	☐	☐	$_____	per _____	___/___/___	___/___/___	___/___/___
Dependent Social Security ☐Child(ren) ☐ Spouse	☐	☐	$_____	per _____	___/___/___	___/___/___	___/___/___
Workers Compensation	☐	☐	$_____	per _____	___/___/___	___/___/___	___/___/___
Company Pension	☐	☐	$_____	per _____	___/___/___	___/___/___	___/___/___
Unemployment Compensation	☐	☐	$_____	per _____	___/___/___	___/___/___	___/___/___
State Cash Sickness Plan (SDI, TDB, DBL, TDI)	☐	☐	$_____	per _____	___/___/___	___/___/___	___/___/___
Other disability income benefits	☐	☐	$_____	per _____	___/___/___	___/___/___	___/___/___

Description _____

State law, in some states, requires the following statement: 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 (in Oregon "may be guilty of insurance fraud") commits a fraudulent insurance act, which (in Oregon "may be subject to prosecution") is a crime and subjects such person to criminal and civil penalties. **This notice does not apply to Virginia.**

AUTHORIZATION TO OBTAIN AND REDISCLOSE INFORMATION

I hereby authorize any hospital, physician, pharmacy or other person, or any health care provider, Insurance Company, Plan Administrator, any Government Agency, Social Security Administration, any information gathering services such as MIB, Inc, or HCI to disclose or furnish to Professional Insurance Company or its representatives, any and all information with respect to any injury or illness including mental illness, drug/alcohol abuse, HIV-related, AIDS or AIDS related information to the extent permitted by law, medical history, consultations, prescriptions, treatments or benefits and copies of all applicable records that may be requested. I also authorize my employer to disclose all information needed to evaluate my claim. A photographic copy of this authorization shall be considered as effective and as valid as the original. This authorization is valid for the duration of the claim up to 24 months from the date it was signed. You have the right to revoke this authorization at any time by writing to Professional Insurance Company at the address listed at the top of this form*. Revocation of this authorization will not affect the rights of anyone who acted in reasonable reliance on the authorization before receiving notice of its revocation. Failure to sign this authorization may impair our ability to process a claim and may be the basis for denying a claim for benefits.

Date **Claimant's Signature** **Phone Number**

( )

Address (No., Street, City, State, Zip Code)

Affiliated Companies: Professional Insurance Company,
In California, PIC Life Insurance Company

ATTENDING PHYSICIAN'S SUPPLEMENTAL STATEMENT
ACCIDENT OR SICKNESS
PLEASE ANSWER ALL QUESTIONS

Policy number_____
Claim number_____

Patient Name _____

1. DIAGNOSIS (including any complications) _____
_____ICD-9 Code _____
   (a) Objective findings (including current MRI, x-rays, EKG, laboratory data and any clinical findings)._____
   _____
   (b) Subjective symptoms _____
   (c) Has patient been hospital confined? ☐ Yes ☐ No
   If yes, name/address of hospital _____
   Confined from _____ through _____

2. DATES OF TREATMENT
   (a) Date of last visit Mo. _____ Day _____ Year _____
   (b) Frequency ☐ Weekly ☐ Monthly ☐ Other (Specify) _____

3. NATURE OF TREATMENT (Including surgery and medications prescribed, if any).

4. PROGRESS
   (a) Is patient Totally Disabled? ☐ Yes ☐ No
   (b) Is patient Partially Disabled? ☐ Yes ☐ No
   (c) When is patient expected to return to work? Mo. _____ Day _____ Year _____
   (d) Has patient reached Maximum Medical Improvement? ☐ Yes ☐ No
   If no, when do you expect a fundamental change? Mo. _____ Day _____ Year _____
   (e) Is patient a suitable candidate for further rehabilitation services? ☐ Yes ☐ No
   If yes, circle applicable services: Medical Psychological Vocational

5. CARDIAC (If applicable)
   (a) Functional capacity ☐ Class 1 (No limitation) ☐ Class 2 (Slight limitation)
   (American Heart Association) ☐ Class 3 (Marked limitation) ☐ Class 4 (Complete limitation)
   (b) Blood Pressure (last visit) systolic/diastolic _____/_____

6. FUNCTIONAL LIMITATIONS – ABILITIES

Indicate frequency per day the listed activity can be performed.
(n – never, o – occasional, f – frequent, c – constant)

LIFTING
_____1-10 lbs.
_____11-25 lbs.
_____26-50 lbs.
_____51-100 lbs.
_____over 100 lbs

CARRYING
_____1-10 lbs.
_____11-25 lbs.
_____26-50 lbs.
_____51-100 lbs.
_____over 100 lbs

Indicate longest single time duration each activity can be performed.

_____Sitting
_____Total time on feet
_____Standing
_____Walking
_____Bending
_____Squatting
_____Stooping

_____Kneeling
_____Inside
_____Outside
_____Working with
_____Other (explain)_____
_____

_____ R Finger Dexterity
_____ L
_____ R Below Shoulders
_____ L
_____ R Above Shoulders
_____ L

Doctor: Please describe fully how patient's symptoms/limitations affect ability to work, e.g. how are work schedule and duties restricted and why?

For Maternity Claims (Describe complications, if any) _____
Date of Delivery _____ **Type of Delivery ☐ Normal ☐ Cesarean**

7. PSYCHIATRIC IMPAIRMENT (if applicable)
   (a) Please define "stress" as it applies to this claimant. _____
   _____
   (b) 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, personal and social adjustment (severe limitations)

8. Doctor: Please include copies of office notes for the period of treatment, test results, available discharge summaries and any consulting physician reports.

Name of Attending Physician (Please Print)	Degree	Telephone	Fax
Street Address	City or Town	State or Province	Zip Code
Signature	Date	Taxpayer ID Number (EIN)	