Please fully complete and

Return by:____________

Please complete and mail back to:

Transguard Insurance Company of America, P.O. Box 2148, Warrenville, IL 60555

SUPPLEMENTARY AND ATTENDING PHYSICIANS STATEMENT

PART I – TO BE COMPLETED BY CLAIMANT

Name	Social Security No.	Date of birth	Policy No.	Claim No.

Address	City	State	Zip	Telephone No. ( )

Please answer the following. Are you entitled to any of the benefits listed below? If you answer yes and have not previously provided us with a copy of your award, please do so.

1. Social Security ☐ Yes ☐ No
2. Pension/Annuity ☐ Yes ☐ No
3. Government (V.A., etc.) ☐ Yes ☐ No
4. Workers' Compensation ☐ Yes ☐ No
5. Other, please specify ☐ Yes ☐ No

____

Are you presently working? Yes ☐ No ☐	If yes, on what date did you resume? Full____________ Part____________	If no, when do you think you will be able to return to work?

If yes, name and address of employer.

I certify that I am totally disabled and the information above is correct to the best of my knowledge and belief.

CLAIMANT SIGNATURE: ____ **DATE:** ______________

The claimant is responsible for the completion of this form at his/her own expense

PART II – TO BE COMPLETED BY ATTENDING PHYSICIAN

Diagnosis:	Date of first visit:	Frequency of visits:

Subjective symptoms	Objective findings (x-rays, lab, etc.)

1. **PROGRESS**

a. Has patient: Recovered _______ Improved _______ Unchanged _______ Retrogressed _______

b. Is patient: Bed Confined _______ Hospital confined _______ House confined _______ Ambulatory _______

c. Hs patient been hospitalized: Yes ____ No ____

Name and address hospital:

2. LIMITATIONS (IF YES, CHECK AND DESCRIBE)

Standing _________ Climbing _________ Bending _________ Use of hands _________ Sitting _________

Walking _________ Stooping _________ Lifting _________ Psychological _________ Other _________

Comments:

FRAUD WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer or insurance company, files a statement of claim containing any materially false, incomplete, or misleading information or conceals any fact material thereto, may be guilty of a fraudulent act, may be prosecuted under state law and may be subject to civil and criminal penalties. In addition, any insurer or insurance company may deny benefits if false information materially related to a claim is provided by the claimant.

PART III – TO BE COMPLETED BY ATTENDING PHYSICIAN - CONTINUED

3. PHYSICAL IMPAIRMENT (* as defined in Federal 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 – 20%)
- ☐ 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:

4. **EXTENT OF DISABILITY**

		From any occupation	From patient's regular occupation
a. Is patient now totally disabled?		Yes _____ No _____	Yes _____ No _____
b. If no, when was patient able to go to work?		Mo. _____ Day _____ 20_____	Mo. _____ Day _____ 20_____
c. If yes, when do you think patient will be ale to return to work?	Approximate date	Mo. _____ Day _____ 20_____	Mo. _____ Day _____ 20_____
	Indefinite _________	Never __________	

5. **DATE OF LAST VISIT**

6. **DATE OF NEXT APPOINTMENT**

6. **TREATMENT PLAN**

7. **REMARKS**

Date	Print name of attending physician
Degree	Signature of attending physician

Address	City	State	Zip	Telephone No. ( )