AMERICAN FIDELITY
a different opinion

American Fidelity Assurance Company | Mail to: Worksite Group Benefits Department
P.O. Box 25160 | Oklahoma City, Oklahoma | 73125-0160
Toll Free Phone # 1-800-662-1113
Toll Free Fax # 1-800-818-3453
americanfidelity.com

Attending Physicians Statement Disability Claim Form to be completed by physician

Name of Patient:	Date of Birth: / /	Social Security Number: / /	Account Number:

DIAGNOSIS

Disabling Diagnoses (including complications):	ICD code:

HISTORY

When did symptoms first appear or accident happen? / /	Date patient first consulted you for this condition? / /
Has the patient ever had the same or similar condition? ☐ Yes ☐ No	If yes, indicate when and describe:
Was the patient referred to you? ☐ Yes ☐ No	If yes, provide full name, address, and phone number of referring physician:
Is the disability work related? ☐ Yes ☐ No	

TREATMENT

Frequency of treatment: ☐ Monthly ☐ Weekly ☐ Other, describe:	Date of next appointment : / /
Please describe current treatment:	
List all dates of treatment or medical attention since the disability began:	
Is patient still under your regular care for this condition? ☐ Yes ☐ No	If no, please explain and provide name and phone number of the current treating physician:
Has the patient been confined to a hospital? ☐ Yes ☐ No If yes, give admit and discharge dates along with name and address of hospital.	Admitted: / / Discharged: / / Admitted: / / Discharged: / /
Name:	Address:

PROGNOSIS

Is patient now Disabled? For Regular occupation? ☐ Yes ☐ No	For any Occupation? ☐ Yes ☐ No
Date total disability began: / /	What is the expected return to work date? / /
Is the patient released to return to work with restrictions? ☐ Yes ☐ No	If yes, From: / / Through: / / Please list return to work restrictions:

IMPAIRMENTS

Anticipated length of disability

What are the disabling impairments that prevent the patient from working?	
☐ Class 1 - No limitation of functional capacity, capable of heavy work. No Restrictions *(0-10%)	☐ 1-2 Months
☐ Class 2 - Medium manual activity *(15-30%)	☐ 2-3 Months
☐ Class 3 - Slight limitation of functional capacity; capable of light work activity *(35-55%)	☐ 3-6 Months
☐ Class 4 - Moderate limitation of functional capacity; capable of clerical/administrative sedentary activity. *(60-70%)	☐ 6-12 Months
☐ Class 5 - Severe limitation of functional capacity: Incapable of minimum sedentary activity *(75-100%)	☐ Greater than 12 Months
	☐ Permanent
Please list functional limitations/restrictions that render your patient temporarily totally disabled:	
Do you expect any improvement or decline in functional status? ☐ Yes ☐ No If yes, please circle improvement or decline.	

PHYSICIAN INFORMATION

Attending Physician's Name & Title: (print)	Specialty:	
Phone:	Fax:	
Mailing Address: (P.O. Box or Street, City, State and Zip Code)		
Form Completed By: (Name & Title)	Signature:	Date: / /

If you require completion of your own authorization for the release of medical records please submit the form along with the physician statement.