



ASSURANT

Employee
Benefits®

Long Term Disability Claim Statement

For your protection, the following disclosures are required by state law and are based on the state where you live:

If you live in the states of Alaska or Oregon, the following statement applies to you:

A person who knowingly and with intent to injure, defraud, or deceive an insurance company, files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

If you live in the states of Arizona or New Jersey, the following statement applies to you:

A person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

If you live in the states of Arkansas, Louisiana, Maryland, or New Mexico, the following statement applies to you:

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

If you live in the state California, the following statement applies to you:

Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

If you live in Colorado, the following statement applies to you:

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

If you live in Delaware, Florida, Idaho, Indiana or Oklahoma, the following statement applies to you:

WARNING: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or application containing any false, incomplete, or misleading information is guilty of a felony. In Florida, it is a felony of the third degree.

If you live in the District of Columbia, Hawaii, Maine, Tennessee, Virginia or Washington, the following statement applies to you:

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

To avoid unnecessary delays, be sure all parts of the Claim Statement are completed according to the instructions, and DO NOT SEPARATE the pages.

Products and services marketed by Assurant Employee Benefits are underwritten and/or provided by Union Security Insurance Company. In this document, the terms "we," "us," "our," and the like, refer to each as applicable.

Listed below are our Regional Benefit Centers and corresponding addresses and toll-free numbers:

Assurant Employee Benefits PO Box 40918 Indianapolis Indiana 46240-0918 • 800.283.3636
Assurant Employee Benefits PO Box 390844 Minneapolis Minnesota 55439-0844 • 800.325.8385
Assurant Employee Benefits (Home Office) PO Box 419568 Kansas City Missouri 64141-6568 • 800.451.4531

If you live in New Hampshire, the following statement applies to you:

Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

If you live in New York the following statement applies to you:

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, commits a fraudulent act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

If you live in Minnesota, the following statement applies to you:

A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

If you live in Ohio, the following statement applies to you:

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

If you live in Texas, the following statement applies to you:

Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

If you live in a state other than mentioned above, the following statement applies to you:

Any person who knowingly and with intent to defraud any insurance company or person files an application for insurance or statement of claimant containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Please read the following instructions carefully for proper completion of the attached Long Term Disability Claim Statement. If this is not fully completed, the Claim Statement will be returned for completion.

Do not separate the pages of this Claim Statement. Additional physician's statements may be obtained from your Regional Benefit Center or by copying the physician's statement included in this statement. Attach any additional physician's statements to the Claim Statement.

After the Employer Section has been fully completed, forward the entire statement to the claimant for completion of the Claimant Statement. If the claimant has returned to work or if the claim is for pregnancy, Part 2 of the Claimant's Statement does not need to be completed. After the Employer and Claimant Statements are fully completed, forward the entire statements to the attending physician(s) for completion of the Physician's Statement. This must be the physician(s) who rendered treatment at the onset of this disability.

Instructions for completion of the Employer's sections follow:

Employer Claim Statement—Part 1

Please indicate at the top of the form whether or not this is a new claim.

- 1.–9. Self-explanatory.
10. Effective date of the claimant's LTD coverage.
11. The last day the claimant actually worked at his/her regular occupation, and the total number of hours worked on his/her last day.
12. The number of days per week and the number of hours per day the claimant was regularly scheduled to work prior to his/her disability.
13. Self-explanatory.
14. This question should be completed if your company had LTD coverage through a different carrier, immediately prior to your Assurant Employee Benefits' coverage. If applicable, provide us with the claimant's effective and termination dates under the **prior plan**.
15. Any other coverages the claimant has with Assurant Employee Benefits. (*i.e., Life, Medical, Dental, etc.*)
- 16.–17. If the claimant has returned to work, advise us of his/her **current** work schedule.
18. Advise us of the outcome of your discussion(s) with the claimant, and if any reasonable accommodations were able to be made to allow the claimant to return to work.
19. The claimant's basic monthly earnings as of the determination date indicated in your LTD policy. If the claimant receives any bonuses, commissions or other unusual compensation, review the Policy Definition of Monthly Earnings and provide supporting documentation.
- 20.–22. LTD benefits may be taxable. These questions are essential for us to make that determination.
23. Self-explanatory.
24. For any source of income marked, please attach payroll records, award notices, denial notices or any other available documentation.
25. Self-explanatory.
26. This portion of the claim statement must be signed by someone other than the claimant who is filing this claim. Be sure to indicate the title or position of the person signing this form.

Employer Claim Statement—Part 2

Fully complete this section of the claim statement for **all** claims.

Please attach a copy of the employer's own description of the claimant's position to this claim statement. If a job description is not available, please attach a separate sheet describing the nature and essential duties of the claimant's position. This section should be completed by someone who is familiar with the claimant's position; i.e., supervisor.

Physical Aspects

1. Self-explanatory.
2. Please tell us how often the claimant does each of the activities listed and the amount(s) of weight, if any, the claimant is required to lift and carry in a typical work day.
 Never = 0 hours
 Occasionally = 1/2–2-1/2 hours
 Frequently = 2-1/2–5-1/2 hours
 Continuously = 5-1/2 hours or more

- 3.–5. Self-explanatory.

Stress/Non Physical Aspects

For each question listed, please indicate how often the claimant is involved in these activities, by providing us with the percentage of the work day the claimant spends in each activity.

Long Term Disability Claim Statement



Employer Claim Statement—Part 1 (Please print or type. If necessary, add separate sheet.)

New claim: Yes No

1. Name of employer _____	2. Policy no. _____	3. Participation no. _____	4. Account no. _____
5. Employer's Business Entity Form (e.g. corporation, professional corporation, professional association, S corporation, partnership, proprietorship)			
6. Does the claimant have an ownership interest in the employer? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," ownership percentage _____%		7. Full legal name of claimant _____	
8. Social Security no. _____	9. Date employed _____	10. Effective date of insurance _____	
11. Date last worked _____ No. of hours worked that day _____	12. Work schedule of claimant at time of disability: _____ Days per week _____ Hours per day		
13. Was claimant a member of a union? <input type="checkbox"/> Yes <input type="checkbox"/> No	14. Was claimant covered under your prior LTD plan? <input type="checkbox"/> Yes <input type="checkbox"/> No Effective date under prior plan _____ Termination date under prior plan _____		
15. Does claimant have any other coverage(s) with Assurant Employee Benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," please advise of the type of coverage(s).			
16. Has claimant returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," on what date: _____ With restrictions _____ Full capacity		17. Current work schedule of claimant? _____ Day(s) per week _____ Hours per day	
18. a. Have you and the claimant discussed reasonable accommodations which would allow a return to work? <input type="checkbox"/> Yes <input type="checkbox"/> No b. Do you have an established return to work program? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes" to either, please explain. c. What accommodations have you implemented?			
19. Basic earnings \$ _____ per <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other _____ How is claimant paid? <input type="checkbox"/> Hourly <input type="checkbox"/> Salaried <input type="checkbox"/> Salary + Commission <input type="checkbox"/> Commission only <input type="checkbox"/> Salary + Bonus Effective date of last salary change _____ <input type="checkbox"/> Other _____			
20. Does claimant contribute towards the cost of this LTD insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," <input type="checkbox"/> Pre-tax <input type="checkbox"/> Post-tax If "Post-tax," _____% premium dollars paid by employer, _____% paid by claimant			
21. Does the employer participate in the Social Security portion of FICA? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," Year-to-date earnings paid to the claimant as of today's date (for FICA determination) \$ _____			
22. Has the claimant's contribution % or the pre/post-tax % changed within the past 4 calendar years? <input type="checkbox"/> Yes <input type="checkbox"/> No			
23. Did this disability occur as a result of the claimant's employment? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Currently disputed If "Yes," or under dispute, please provide us with the policy no., name, address and phone no. of Workers' Compensation administrator.			
24. To the best of your knowledge, is the claimant receiving, or entitled to receive benefits from any of the following sources? <input type="checkbox"/> Salary continuance Amount: _____ per _____ From _____ to _____ <input type="checkbox"/> Workers' Compensation Weekly benefit _____ Effective date _____ <input type="checkbox"/> Retirement or pension Benefit amount _____ Effective date _____ <input type="checkbox"/> National Guard/Military Reserve Pay <input type="checkbox"/> Other _____ Lump sum distribution? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Do you wish to have disability checks sent directly to claimant's home? <input type="checkbox"/> Yes <input type="checkbox"/> No			
26. Date _____		By _____ AUTHORIZED BY (PLEASE PRINT)	
Fax no. _____		By _____ AUTHORIZED SIGNATURE/TITLE	
Phone no. _____		E-mail address _____	

DO NOT SEPARATE

**Employer Claim Statement—Part 2
Physical/Non Physical Aspects of Job**

Please complete this section of the claim statement to provide us with information concerning the physical/non physical demands of claimant's job. Attach a narrative job description if available.

Claimant's Job Title _____

Signature/Title _____

Date _____

Physical Requirements

1. In a typical work day, give the number of hours the claimant spends in each of these positions and if claimant may alternate positions:

Position	Total No. of Hours	May Alternate Positions			
		At Will	15–30 Minutes	Hourly	Never
Sitting	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Driving	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STAPLE YOUR OWN JOB DESCRIPTION HERE

2. Claimant must	Never	Occasionally (1/4–2 1/2 hours)	Frequently (2 1/2–5 1/2 hours)	Continuously (5 1/2–8 hours)
A. Bend/Stoop	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Climb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Reach above shoulder level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Kneel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Balance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. Enter data/keystroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. Squat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. Crawl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I. Crouch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
J. Lift: Usual _____ lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Max _____ lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
K. Carry Usual _____ lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Max _____ lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L. Push/Pull Usual _____ lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Max _____ lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. On the job, claimant uses feet for repetitive movements as in operating foot controls.
 Right: Yes No Left: Yes No Both: Yes No

4. On the job, claimant uses hands for repetitive action such as:

	Simple Grasping	Firm Grasping	Fine Manipulation
A. Right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5. Does job require:

A. Working at unguarded heights? Yes No

B. Exposure to marked changes in temperature and humidity or extremes thereof? Yes No

C. Exposure to dust, fumes, gases, chemicals? Yes No

Stress/Non Physical

1. Percentage of time claimant spends answering customer complaints. _____ %
2. Percentage of claimant's work primarily judged on production. _____ %
3. Does this claimant depend upon the assistance of others in order to accomplish his/her daily tasks?
 Yes No _____ % of time
4. How many employees does this claimant supervise? _____
5. Is this claimant routinely subject to close supervision? Yes No
6. Percentage of time spent by the claimant working with his/her co-workers. _____ %
7. Percentage of claimant's time spent on: _____ % Prescheduled activities
 _____ % Random activities
8. Percentage of time claimant spends meeting deadlines set by others. _____ %
9. Percentage of responsibility the claimant has for the performance of his/her particular department. _____ %

DO NOT SEPARATE

Section I Attach additional pages if needed

1. Full name (as it appears on your Social Security card)	2. Social Security no.	3. Date of birth	4. Home phone no.
5. Address (street, city, state, zip code)		6. Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	7. E-mail address
8. Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	9. Your job title		10. Cell phone no.
11. Names and birthdates of spouse and all dependent children under age 18.			

Section II

1. Nature of illness and when symptoms first appeared, or describe how and where accident occurred. If motor vehicle accident, in what state did accident occur? _____	2. Date first unable to work because of this disability.			
3. Have you returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," on what date: _____ Part-time _____ Full-time If you have not returned to work, on what date do you expect to return to work? _____ Part-time _____ Full-time				
4. Please provide the names and addresses of all physicians who have been consulted for this condition. Please include dates of consultation.				
Name	Address (city, state)	Phone no.	First Visit	Last Visit
5. If you have been hospital confined for this disability, please provide name and address of hospital and confinement dates.				
Name of Hospital	Address	From	To	
6. Please provide name, address and phone number of your pharmacy.				

Section III

1. Check if you are receiving or entitled to receive benefits from any of the following sources:				
<input type="checkbox"/> Salary, Wages or Commissions	<input type="checkbox"/> Retirement or Pension Plan	<input type="checkbox"/> Railroad Retirement Act		
<input type="checkbox"/> State Disability	<input type="checkbox"/> Social Security Disability	<input type="checkbox"/> National Guard/Military Reserve		
<input type="checkbox"/> Workers' Compensation	<input type="checkbox"/> Social Security Retirement	<input type="checkbox"/> Other sources		
For each source marked above, please provide us with the following information:				
Source	Amount of Income		Date	Benefit
	Amount	Frequency	Application Filed	Effective Date
Provide documentation of any source indicated above; i.e., award notices, denial notices or applications.				
2. Do you have medical insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No Policy no., name, address and phone no. of medical plan administrator.				
Please indicate the type of coverage provided <input type="checkbox"/> COBRA <input type="checkbox"/> Other (Specify) _____				

I authorize any provider of medical services, insurance company, consumer reporting agency, Social Security Administration, governmental agency, educational institute, law enforcement agency, or employer having medical information with respect to any physical or mental condition, rehabilitation and other non-medical information of me to give to Union Security Insurance Company, or its representative, any and all such information. I understand Union Security Insurance Company may discuss my limitations/restrictions with treating physicians and current or prospective employers as they relate to accommodations and possible return to work. **I UNDERSTAND** the information obtained by use of this Authorization will be used by Union Security Insurance Company to determine the eligibility for benefits. I know that a photographic copy of this authorization shall be as valid as the original. I agree this Authorization shall be valid for the duration of the claim. This authorization is not governed by HIPAA, however, when necessary, I may be asked to execute a HIPAA authorization form, allowing Union Security Insurance Company to use and disclose protected health information.

If I receive a disability benefit greater than that which I should have been paid, I understand this insurance company has the right to recover such overpayments from me, including the rights to reduce or adjust future benefits, if any.

Signature of claimant _____ Date _____

HIPAA Authorization For Release of Protected Health Information



Insured/Member name _____ SSN _____ DOB _____

Address _____ City _____ State _____ Zip _____

Policy no. _____ Participation no. _____ Account no. _____ Certificate no. _____

Persons/categories of persons providing the information: Any provider of medical services, insurance company, pharmacy, pharmacy benefits manager, or any pharmacy-related services entity, Social Security Administration, governmental agency, vocational provider or employer having medical information with respect to any physical or mental condition of mine.

Persons/categories of persons receiving the information: Union Security Insurance Company or Union Security Life Insurance Company of New York ("Companies").

I hereby authorize the use or disclosure of my protected health information as described below:

Information to be disclosed: All information necessary to allow the Companies or its representatives to determine my eligibility for benefits and to process my claim. Such information may include, but is not limited to: Any and all medical/dental records relating to my physical and/or mental health whether for treatment or evaluation purposes, pharmacy records, and strength/functional testing.

The sole purpose of this disclosure is for the adjudication of my claim for insurance benefits under the above-referenced Policy.

I understand the following:

- I have the right to refuse to sign this authorization; however, if I refuse to sign this authorization, I understand that the Companies may not be able to gather the information necessary to determine if I am eligible for coverage or benefits under one of the Companies' insurance policies. I understand that a photocopy or facsimile of this authorization is as valid as the original. Upon request, I may receive a copy of this authorization.
- This authorization is voluntary. I may revoke it any time by writing Assurant Employee Benefits, Privacy Office, PO Box 419052, Kansas City, MO 64141-6052. Any such revocation will not affect any actions that Companies took before receipt of the revocation.
- Federal law requires that we inform you that the information that we collect may, under certain circumstances, be re-disclosed by us to third parties and thus no longer protected by federal law. Oklahoma only - we are required to inform you that **the information authorized for release may include information which may indicate the presence of a communicable disease or noncommunicable disease.**
- I understand that any information obtained by this authorization may be used and disclosed by HIPAA and non-HIPAA plans.
- This authorization is effective from the date signed below until my claim ends.

SIGNATURE OF INSURED/MEMBER OR LEGAL PERSONAL REPRESENTATIVE

DATE

PRINTED NAME OF LEGAL PERSONAL REPRESENTATIVE

RELATIONSHIP TO INSURED/MEMBER

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

Please mail or fax your Authorization to the appropriate address listed below:

Assurant Employee Benefits PO Box 40918 Indianapolis Indiana 46240-0918 • F 317.205.2201
Assurant Employee Benefits PO Box 390844 Minneapolis Minnesota 55439-0844 • F 952.920.4577
Assurant Employee Benefits (Home Office) PO Box 419568 Kansas City Missouri 64141-6568 • F 816.881.8768

The patient must pay any costs for completion of this form.

To the Attending Physician

Please read the following instructions before completing this form.

Do not separate the pages of this claim statement.

Authorizations to release information can be found on pages 8 and 9.

Clearly print or type this form. Fully complete each applicable section of this form. Review the attached Job Description and Training, Education and Experience sections before completing the last page of this form. The Job Description is Part 2 of the Employer's Claim Statement, and the Training, Education and Experience section is Part 2 of the Claimant's Statement.

Sign and date this form after completion. Also, clearly print or type your name, address and phone number in the spaces provided. If applicable, include your fax number.

After you have completed this form, return the entire claim statement to the patient.

Name of patient _____	Date of birth _____	Social Security number _____
History	Patient's symptoms result from <i>(Check all that apply.)</i> : <input type="checkbox"/> Employment <input type="checkbox"/> Illness <input type="checkbox"/> Accident <input type="checkbox"/> Motor Vehicle Accident <input type="checkbox"/> Pregnancy If pregnancy, <i>(expected/actual delivery date)</i> _____ Type of delivery _____ Date symptoms first appeared _____ Patient's height _____ Weight _____ Name(s), address(es), specialty(ies) of other treating or referring physician(s) _____ First visit for this condition _____ Most recent visit _____ Most recent comprehensive exam _____ Hospital name _____ Confinement dates _____ thru _____	
	Diagnoses	
	Diagnoses with ICD9-CM codes: list in descending order of severity <i>(including any complications)</i> . Please go to the appropriate assessment section and elaborate. ICD9 _____	
	Subjective symptoms _____	
	Objective findings _____	
Attach medical records which document the above diagnostics. <i>(Include results/copies of x-rays, lab tests, EKGs, MRIs and scans)</i>		
Functional Assessment	In terms of an 8 hour day: <input type="checkbox"/> Class 1—No limitation; capable of heavy work*—exert 50–100# occasionally and/or 25–50# force frequently. <input type="checkbox"/> Class 2—Medium activity*—exert occasional 20–50# force and/or 10–25# force frequently. <input type="checkbox"/> Class 3—Slight limitation; capable of light work*—exert occasional 20# force and/or up to 10# force frequently. <input type="checkbox"/> Class 4—Moderate limitation; capable of sedentary*, clerical or administrative work—occasional 10# force, mostly sitting. <input type="checkbox"/> Class 5—Severe limitation; incapable of minimal activity or sedentary* work. <input type="checkbox"/> Bed confined <input type="checkbox"/> House confined <small>*As defined by the U.S. Department of Labor's Federal Dictionary of Occupational Titles</small>	
	Please fully describe the patient's capabilities: *With allowance for positional change. N =Never O =Occasionally (1/4–2 1/2 hours) F =Frequently (2 1/2–5 1/2 hours) C =Continuously (5 1/2–8 hours) _____ Standing* _____ Sitting* _____ Walking* _____ Driving* _____ Bending* _____ Data Entry* Lifting not more than _____ pounds _____(how often) Carry not more than _____ pounds _____(how often)	
	When did these capabilities begin? _____	
	Do you anticipate an increase in your patient's functional capabilities? If so, what date _____	

