



REQUEST FOR PROOF OF CONTINUANCE OF TOTAL DISABILITY

DATE: \_\_\_\_\_

RE: POLICY

In accordance with the terms of the Disability Benefits Provision in your policy, the Company may from time to time require proof of the continuance of your Total Disability. At this time, please answer **either** Section **A** or Section **B** below, whichever applies in your case. Your attending physician must complete the reverse side.

**SECTION A.** If you are no longer totally disabled:

Home phone # ( ) \_\_\_\_\_ Work phone # ( ) \_\_\_\_\_

On what date did you return to work, or resume normal activities.

If not working, what are your plans for returning to work?

**SECTION B.** If you are still totally disabled:

Home phone # ( ) \_\_\_\_\_ Work phone # ( ) \_\_\_\_\_

Employer: \_\_\_\_\_

Address: \_\_\_\_\_

1. What occupational duties are you still unable to perform? \_\_\_\_\_

2. Have you been to your place of employment since the last report? \_\_\_\_YES \_\_\_\_NO If yes, for what reason? \_\_\_\_\_

3. Since the last report you completed, has your condition: \_\_\_\_IMPROVED \_\_\_\_WORSENERD \_\_\_\_REMAINED THE SAME  
Please explain. \_\_\_\_\_

4. Describe any routine chores performed at home (cook, clean, yard work, etc.). \_\_\_\_\_

5. Do you have any hobbies (reading, television, gardening, bowling, etc.)? \_\_\_\_\_

6. Date of last doctor's appointment \_\_\_\_/\_\_\_\_/\_\_\_\_. Medications? \_\_\_\_\_

7. Are you in a rehabilitation program? Describe: \_\_\_\_\_

8. What other benefits are you receiving? List sources: \_\_\_\_\_

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person files a 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 and is guilty of a felony or misdemeanor.

The undersigned hereby makes claim to the above company for total disability or benefits and agrees that, by furnishing this or any other form or by investigating this claim, the Company shall not be deemed to have admitted the validity of said claim or to have waived any of its rights or defenses.

To assist John Hancock in processing my claim. I authorize the Medical Information Bureau, the Social Security Administration and any clinic, hospital, physician, governmental agency, insurer, organization or person having any knowledge or information of me (including, but not limited to my : employment, disabilities and health) to furnish the same to the John Hancock, orally or in writing, as may be requested by them or their duly authorized representatives. I understand that this executed authorization expressly waives any right for the above information to be privileged. A photocopy of this authorization is as valid as the original and shall remain in effect for a period of twelve months from the date of completion.

Date \_\_\_\_\_ Claimant \_\_\_\_\_ Relationship \_\_\_\_\_ Age \_\_\_\_\_  
Signature (If not the Insured)



**CONTINUANCE OF  
TOTAL DISABILITY**

**ATTENDING  
PHYSICIAN'S  
STATEMENT**

**LIFE DISABILITY CLAIMS  
TO BE COMPLETED BY ATTENDING PHYSICIAN**

PATIENT'S NAME AND DATE OF BIRTH \_\_\_\_\_

**1. DIAGNOSIS AND CONCURRENT CONDITIONS**

2A. WHEN DID PATIENT FIRST CONSULT YOU?	DATE _____
B. WHEN DID PATIENT FIRST CONSULT YOU FOR THIS CONDITION?	DATE _____
C. WHEN DID THE SYMPTOMS FIRST OCCUR?	DATE _____
D. WAS THERE ANY PREVIOUS HISTORY OF THIS INJURY/ILLNESS?	YES <input type="checkbox"/> NO <input type="checkbox"/>
E. ON WHAT DATE WAS IT ORIGINALLY SUSTAINED OR CONTRACTED?	DATE _____

3A. NATURE OF SURGICAL PROCEDURE, IF ANY (Describe Fully)	DATE PERFORMED _____
B. IF PERFORMED IN HOSPITAL GIVE NAME OF HOSPITAL	

4A. GIVE DATES OF OTHER MEDICAL (NON-SURGICAL) TREATMENT, IF ANY	DATE _____
B. DATE LAST SEEN	OFFICE _____ HOME _____ HOSPITAL _____
C. PLEASE DESCRIBE THE NATURE OF TREATMENT, FREQUENCY OF TREATMENT, INCLUDING MEDICATION, DOSAGES, ETC	
D. WHAT OTHER SPECIALISTS HAVE EVALUATED OR TREATED THIS PATIENT?	

5. IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? IF "NO" GIVE DATE YOUR SERVICES TERMINATED AND REASON FOR TERMINATION.	YES <input type="checkbox"/> NO <input type="checkbox"/> DATE _____
A. WHO WAS THE PATIENT REFERRED TO?	

6A. HOW LONG WAS OR WILL PATIENT BE CONTINUOUSLY TOTALLY DISABLED? (Unable to work)?	FROM _____ THRU _____
B. HOW LONG WAS OR WILL PATIENT BE PARTIALLY DISABLED?	FROM _____ THRU _____

**DOCTOR - PLEASE ANSWER THE FOLLOWING: (Please attach additional sheets if needed)**

Is the patient able to perform any of the duties of any occupation or employment for pay or profit for which the patient is reasonably fitted by education, training, or experience?

What are the patient's limitations and/or restrictions which impair vocational functioning? Please describe specifically what your patient can and cannot do now.

Can the patient perform the duties of a sedentary type occupation?

What is the patient's prognosis?

What is the patient's educational level?

Name \_\_\_\_\_ Degree \_\_\_\_\_ Specialty \_\_\_\_\_  
(Please Print)

Signature \_\_\_\_\_ Date \_\_\_\_\_  
(Attending Physician)

Address \_\_\_\_\_ Phone # ( ) \_\_\_\_\_ Fax # ( ) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_