



ATTENDING PHYSICIAN'S STATEMENT

TOTAL DISABILITY

LIFE DISABILITY CLAIMS TO BE COMPLETED BY ATTENDING PHYSICIAN

PATIENT'S NAME _____ 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 NO

(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 OFFICE _____

(B) DATE LAST SEEN HOME _____

(C) PLEASE DESCRIBE THE NATURE OF TREATMENT, FREQUENCY OF TREATMENT, INCLUDING MEDICATION, DOSAGES, ETC. HOSPITAL _____

(D) WHAT OTHER SPECIALISTS HAVE EVALUATED OR TREATED THIS PATIENT? _____

(5A) IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? IF "NO" GIVE DATE YOUR SERVICES TERMINATED AND THE REASON FOR TERMINATION. YES NO DATE _____

(B) WHOM 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)

- 1. 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? YES NO
2. What are the patient's limitations and/or restrictions which impair vocational functioning? Please describe specifically what your patient can and cannot do now.
3. Can the patient perform the duties of a sedentary type occupation? YES NO
4. What is the patient's prognosis?
5. What is the patient's educational level?

Name _____ (Please print) Degree _____ Specialty _____

Signature _____ (Attending physician) Date ____/____/____

Address _____ Phone # () _____

City _____ State _____ Zip _____

PATIENT IS RESPONSIBLE FOR ANY EXPENSE INVOLVED IN THE COMPLETION OF THIS FORM

Administrative Office
P.O. Box 506
Keene, NH 03431-0506



IF YOU HAVE A QUESTION REGARDING THE STATUS OF YOUR CLAIM, YOU MAY TELEPHONE 1-800-310-8319

TOTAL DISABILITY
(Please Print)

List all Policy Numbers for Which Claim is Made

1. _____ 2. _____ 3. _____ 4. _____ 5. _____

Name _____ D.O.B. ____/____/____ S.S.# [][]-[][]-[][][][]

Residence _____ City _____ State _____ Zip _____

Employer _____ Occupation _____

Employer Address _____ City _____ State _____ Zip _____

Home Phone () _____ - _____ Work Phone () _____ - _____

TO AVOID DELAY, COMPLETE ALL SECTIONS FULLY. USE ADDITIONAL PAPER AS NEEDED.

1. List the duties/tasks required to perform this job:

2. Specify which aspects of this job the insured can and cannot do:

3. Describe the illness/injury that prevents insured from working:

4. Was there any previous history of this injury or disease? Yes No
On what date was it originally sustained or contracted? _____
(MM/DD/YY)

5. When did the Insured first consult or when was he first attended, treated or examined by a physician or other practitioner or first treated or examined in a hospital or other institution for or in connection with this injury or disease? _____ MM/DD/YY

6. State the names and addresses of all physicians or other practitioners and all hospitals or other institutions by whom or in which the Insured has been attended, treated or examined for or in connection with this injury or disease.

Name	Address	MM/DD/YY
_____	_____	_____
_____	_____	_____

7. From what date has the Insured been continuously prevented from engaging in any work, occupation or business? (must have been unable to work for six (6) consecutive months) _____ MM/DD/YY

8. If the Insured is now able to engage in some work, occupation or business, on what date did he return to gainful employment? _____ MM/DD/YY

9. If the Insured is totally disabled, when is it expected he might be able to return to some gainful employment? State approximate date. _____ MM/YY

10. Indicate if the Insured has been deemed disabled by the _____ Name of Organization _____ Degree of Disability _____
John Hancock or any other insurance Company, Governmental agency, _____
Union Welfare Plan or employer-employee benefit organization. _____

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 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 the Hancock in processing my claim, I authorize the Consumer Reporting Agencies, 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 twenty-four months from the date of completion.

Date _____ Claimant Signature _____ Relationship _____ Age _____
(If not the insured)