Disability Benefits Continuance Claim

For Claims Customer Service: ☎ **Phone:** (877) 201-9373 x45708
For Claims Submission: 🖷 **Fax:** (508) 854-7125 ✉ **Email:** DICIClaimsVB@trustmarkbenefits.com

The patient is responsible for the completion of this form by his/her physician without expense to this Company.

Name of insured/patient: _____ Date of Birth: _____

Attending Physician Statement *(To be completed by the physician)*

(Please answer all questions pertaining to current disability)

Treatment

Date of 1st visit: _____ Date of last visit: _____ Frequency: ❑ Weekly ❑ Monthly ❑ Other: _____

Have you referred patient to any other physicians? If so, please provide name(s) and address(es):

_____

_____

Current medications, dosage & frequency		
Medication	**Dosage**	**Frequency**

Nature of treatment: _____

_____

Will treatment substantially improve function and employability? ❑ Yes ❑ No

Diagnosis

Current Diagnosis (including ICD code): _____

Subjective symptoms: _____

Objective findings since last report (including results of X-rays, EKG's, laboratory data, clinical findings, etc.):

_____

Physical impairment (check one)

❑ No limitation of functional capacity; Capable of heavy physical activity. No restrictions
❑ Capable of medium manual activity
❑ Slight limitation of functional capacity; Capable of light manual activity/work
❑ Moderate limitation of functional capacity; Capable of clerical / administrative or sedentary activities
❑ Severe limitation of functional capacity; incapable of minimal (sedentary) activities

Mental / Nervous impairment (if applicable)

❑ Able to function under stress & engage in interpersonal relations (no limitations)
❑ Able to function in most stress situations & engage in most interpersonal relations (slight limitations)
❑ Able to engage in only limited stress situations & engage in only limited interpersonal relations (moderate limitations)
❑ Unable to engage in stress situations or engage in interpersonal relations (marked limitations)
❑ Significant loss of psychological, physiological, personal and social adjustment (severe limitations)

Do you believe the patient is competent to endorse checks and direct the use of the proceeds thereof? ❑ Yes ❑ No

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Attending Physician Statement *(To be completed by the physician) (Continued)*

Name of insured/patient: _____ Date of Birth: _____

Prognosis Patient has: ❑ Recovered ❑ Improved ❑ Not Changed ❑ Retrogressed

	Patient's Occupation	Any Other Work
In your opinion, is patient now impaired from:	❑ Yes ❑ No	❑ Yes ❑ No
Date released from work:		
If not currently ready, when will patient recover sufficiently to perform duties:		

Please explain why patient remains unable to work: _____

Please explain what needs to change to allow patient to return to work: _____

Is patient able to do some work, but cannot work more than 50% of their regularly scheduled job? Yes ❑ No ❑

If yes, for what period of time do these restrictions limit the patient? From: _____To: _____ Describe work restrictions: _____

Rehabilitation

	Patient's Occupation	Any Other Work
Is your patient a suitable candidate for trial employment?	❑ Yes ❑ No	❑ Yes ❑ No
If yes, when could trial employment begin?	_____ ❑ Full Time ❑ Part Time	_____ ❑ Full Time ❑ Part Time
If not currently ready, when will patient recover sufficiently to perform duties:		

Remarks: _____

FRAUD NOTICE: Any person who knowingly files a statement of claim containing false or misleading information is subject to criminal and civil penalties. This includes Employer and Attending Physician portions of the claim form.

Physician's Name: (please print): _____

Specialty: _____

Address: _____

Phone: (____) _____ Fax: (____) _____

Signature: _____ Date Signed: _____

Please attach copies of all medical records relating to the claim condition including treatment notes & test results.

May we communicate with you using email? ❑ Yes ❑ No Email Address: _____