Ullico
SOLUTIONS FOR THE UNION WORKPLACE

PHYSICIAN'S STATEMENT
(DISABILITY)
PLEASE PRINT

Please submit this form to:
The Union Labor Life Insurance Company
Claim Service Center
1500 Main Street, Suite 1400, PO Box 15309
Springfield, MA 01115-5189
Toll free: (888) 855-4261 • Fax: (860) 769-6986

PATIENT INFORMATION

Name:			DOB:
Patient's height:	Weight:	BP:	SSN:
Primary diagnosis:			ICD-9 Code:
Secondary diagnosis:			ICD-9 Code:

DIAGNOSIS (Required)

Procedures:			ICD-9 Code:
Diagnostic tests performed:		Results:	Date:
		Results:	Date:
Subjective symptoms:		Objective signs:	
Date of first visit for illness/injury:	Date patient became disabled:	Date of last office visit:	Date of next office visit:

Is this due to an accident? ☐ Yes ☐ No

PSYCHIATRIC IMPAIRMENT (if applicable)

- ☐ Class 1 Able to function under stress and engage in interpersonal relationships (no limitations)
- ☐ Class 2 Able to function in most stressful situations and engage in most interpersonal relationships (no limitations)
- ☐ Class 3 Able to function in limited stressful situations and in limited interpersonal relationships (moderate limitations)
- ☐ Class 4 Unable to engage in stressful situations or in interpersonal relationships (marked limitations)
- ☐ Class 5 Significant loss of psychological, physiological, personal and social adjustments (severe limitations)

CARDIAC (if applicable) America Heart Association functional capacity

☐ Class 1 (no limitation) ☐ Class 2 (slight limitation) ☐ Class 3 (marked limitation) ☐ Class 4 (complete limitation)

CURRENT PLAN OF TREATMENT (Required for all conditions)

Frequency of current visits: ☐ Weekly ☐ Monthly ☐ Other (specify):

Medication name:	Dosage:
Medication name:	Dosage:

Therapy prescribed: ☐ Physical therapy ☐ Occupational therapy ☐ Speech therapy Frequency:

Is Patient Compliant with Therapy? ☐ Yes ☐ No Tolerance To Therapy: ☐ Good ☐ Poor

SUSTAINED TOLERANCE TO: (Please check appropriate boxes)

Sit	☐ 0 hrs	☐ 1 hr	☐ 2 hrs	☐ 3 hrs	☐ 4 hrs	☐ 5 hrs	☐ 6 hrs	☐ 7 hrs	☐ 8 hrs
Stand	☐ 0 hrs	☐ 1 hr	☐ 2 hrs	☐ 3 hrs	☐ 4 hrs	☐ 5 hrs	☐ 6 hrs	☐ 7 hrs	☐ 8 hrs
Walk	☐ 0 hrs	☐ 1 hr	☐ 2 hrs	☐ 3 hrs	☐ 4 hrs	☐ 5 hrs	☐ 6 hrs	☐ 7 hrs	☐ 8 hrs

Indicate what accommodations would increase tolerance to any of the above:

PLEASE COMPLETE REVERSE SIDE

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PHYSICIAN'S STATEMENT

(DISABILITY)

SIDE 2

PATIENT CAN LIFT / CARRY: (Please check appropriate boxes)

Maximum pounds	<10	10	15	20	25	30	35	40	45	50	55	60	65	75	80	85	90	95	100	125	≥ 150
Occasionally (0 - 2.5 hrs / day)																					
Frequently (2.5 - 5.5 hrs / day)																					
Continuously (5.5+ hrs / day)																					
Never																					

PATIENT CAN USE UPPER EXTREMITIES FOR REPETITIVE TASKS

	Simple grasping	Pushing / pulling	Fine manipulation
Right hand	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Left hand	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Both hands	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

PATIENT CAN USE LOWER EXTREMITIES FOR REPETITIVE MOVEMENTS (i.e., foot controls)

	Climb	Balance	Stoop	Kneel	Crouch	Crawl	Reach	Handle	Finger	Feel
Not at all										
Occasionally (0 - 2.5 hrs / day)										
Frequently (2.5 - 5.5 hrs / day)										
Continuously (5.5+ hrs / day)										

Estimated return to work date: ☐ With restrictions (date): ☐ Without restrictions (date):

Has this patient reached maximum medical improvement? ☐ Yes ☐ No If no, anticipated date of MMI:

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

NOTICE: Any person who knowingly and with intent to defraud or deceive any insurance company or other person files a statement of claim containing any materially false or misleading information, or conceals for the purpose of misleading, information concerning any fact material hereto COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME and in certain states, a felony. Penalties may include imprisonment, fines, denial of insurance and civil damages. In New York, there are also civil penalties not to exceed $5,000 and the stated value of the claim for each such violation. Under penalties of perjury, I certify that the above statements and answers are true and correct to the best of my knowledge.

Print attending physician name: Specialty:

Address:

City: State: Zip:

Phone: Fax:

Physician's signature: Date:

X

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