## **Long Term Disability**

## Claim Notice and Attending Physician's Statement of Disability

## COUNTY OF SAN MATEO

ATTN: LTD ADMINISTRATOR 455 COUNTY CENTER, 5TH FLOOR REDWOOD CITY, CA 94063

The patient is responsible for the completion of this form without expense to the employer.

Jack	Contract number	t number Division/location				Employee's name				
Date of bish    Sax	Cosini Convity number	I Smalaus	Employee's home address							
Jack	Social Security Humber	Employee	s nome aud	ress						
Under the Long Term Disability Plan, an employee is eligible to receive benefits if medically disabled from performing the duties of his own occupation. These benefits are payable for months and only continued if then disabled from performing the duties of any occupation according to their training, education, and experience.  In order to determine benefit eligibility and rehabilitation, answer the following:  HISTORY  When did symptoms first appear or accident happen?	Date of birth	D Wanted D		Date employed		Occupa	tion			
If his own_occupation. These benefits are payable formonths and only continued if then disabled from performing the duties of any occupation according to their training, education, and experience.  In order to determine benefit eligibility and rehabilitation, answer the following:  HISTORY  When did symptoms first appear or accident happen?		☐ Single ☐	Widowed							
Julies of any occupation according to their training, education, and experience. In order to attentine benefit eligibility and rehabilitation, answer the following:  HISTORY  When did symptoms first appear or accident happen?  Month	Under the Long Term	Disability Plan, an e	mployee	is eligible to	receive benefit	s if medi	cally disabled from	performing the duties		
IN order to determine benefit eligibility and rehabilitation, answer the following: HISTORY When did symptoms first appear or accident happen?	of his own occupatio	<u>n</u> . These benefits ar	e payable	e for m	onths and only	y continu	ied if then disable	d from performing the		
When did symptoms first appear or accident happen?  Month Day, 19					and experience	9.				
When did symptoms first appear or accident happen?		эн өндөнку апо гепавика	tion, answe	r the following:						
Date patient ceased work because of disability:		an?	Month Day 10							
PRESENT CONDITION    Dispertive symptoms										
DIAGNOSIS  PROGNOSIS  TREATMENT  Date of visit?  Date of visit?  Date of visit?  Date of visits:    Month   Day   19							Jay, 19			
DIAGNOSIS  PROGNOSIS  TREATMENT Date of Visit?  Month Day 1, 19 Day 19 D			altions:		D 162 D1	NO		18 E E		
DIAGNOSIS  PROGNOSIS  TREATMENT  Date of visit?	Subjective symptoms		Objective findings							
TREATMENT  Date of visit?					, , , , , , , , , , , , ,	-				
TREATMENT  Date of visit?										
Date of visit?    Month   Day   19	DIAGNOSIS				PROGNOSIS					
Date of visit?    Month   Day   19   Part										
Date of visit?    Month   Day   19   Date of last visit?   Month   Day   19   Date of last visit?   Month   Day   19   Date of last visit?   Month   Day   19   Date of last visits:   Weekly   Monthly   Other   When did you actually examine the patient?   Month   Day   19   Day   19   Day   19   Day   19   Day										
Date of visit?    Month   Day   19   Part	i i		<u> </u>							
Date of last visit?    Month   Day   , 19										
Weekly   Monthly   Other										
When did you actually examine the patient?										
EXTENT OF DISABILITY  1. Is the employee totally disabled from performing the duties of his own occupation? (See job analysis completed by employee and/or employer.)										
1. Is the employee totally disabled from performing the duties of his own occupation? (See job analysis completed by employee and/or employer.)   Yes   No	when did you actual		Month		Day, 19	-				
and/or employer.)										
(If "yes," when?	<ol> <li>Is the employee to and/or employer.)</li> </ol>	tally disabled from pe	erforming	the duties of	his own occup	ation? (S	See job analysis co	mpleted by employee		
3. If you answered "no," do you anticipate a release to a less physically and/or emotionally demanding occupation?	<ol><li>If the disability is r</li></ol>	not considered total a	and perm	anent, do yo	u anticipate a i	release t	o his <u>own</u> occupati	ion? ☐ Yes ☐ No		
(If "yes," when?	(If "yes," when? _		)							
(If "yes," when?	3. If you answered "n	o," do you anticipate	a release	to a less phy	sically and/or e	emotional	ly demanding occu	pation? ☐ Yes ☐ No		
and/or MEDICAL/REHABILITATION?  If the employee is disabled from his own occupation but appropriate for rehabilitation or a release to a less demanding occupation, please complete the physical capacity evaluation on the back side of this form. This is used to eventually lend direction in exploring vocational alternatives.  MENTAL CONDITION  Is the patient competent to endorse checks and direct the use of the proceeds thereof?  Yes No  Complete the appropriate section below if disability is due to CARDIAC CONDITION or VISUAL IMPAIRMENT.  CARDIAC  Functional capacity (American Heart Association):  Class 1 (No limitation)  Class 3 (Marked limitation)  Blood pressure:  Class 2 (Slight limitation)  Class 4 (Complete limitation)  VISUAL IMPAIRMENT  What was vision at last observation?  O.D. O.S. Month Day Year										
MENTAL CONDITION  Is the patient competent to endorse checks and direct the use of the proceeds thereof?  Yes  No  Complete the appropriate section below if disability is due to CARDIAC CONDITION or VISUAL IMPAIRMENT.  CARDIAC  Functional capacity (American Heart Association):  Class 1 (No limitation)  Class 3 (Marked limitation)  Blood pressure:	<ol><li>If the employee ca and/or MEDICAL/</li></ol>	annot perform the du REHABILITATION?	ties of his	s own occupa	ation, would yo	ou feel it	appropriate to con-	sider VOCATIONAL		
MENTAL CONDITION  Is the patient competent to endorse checks and direct the use of the proceeds thereof?  Yes  No  Complete the appropriate section below if disability is due to CARDIAC CONDITION or VISUAL IMPAIRMENT.  CARDIAC  Functional capacity (American Heart Association):  Class 1 (No limitation)  Class 3 (Marked limitation)  Blood pressure:  Class 2 (Slight limitation)  Class 4 (Complete limitation)  VISUAL IMPAIRMENT  What was vision at last observation?  O.D. O.S. Month Day Year  With glasses	If the employee is disable ical capacity evaluation or	d from his own occupation the back side of this forn	but approp n. This is us	oriate for rehabil sed to eventually	itation or a release lend direction in	e to a less exploring v	demanding occupation, ocational alternatives.	please complete the phys-		
CARDIAC  Functional capacity (American Heart Association): Class 1 (No limitation) Class 3 (Marked limitation)  Blood pressure: Class 2 (Slight limitation) Class 4 (Complete limitation)  VISUAL IMPAIRMENT  What was vision at last observation?  O.D. O.S. Month Day Year  With glasses										
CARDIAC  Functional capacity (American Heart Association): Class 1 (No limitation) Class 3 (Marked limitation)  Blood pressure: Class 2 (Slight limitation) Class 4 (Complete limitation)  VISUAL IMPAIRMENT  What was vision at last observation?  O.D. O.S. Month Day Year  With glasses	Is the patient compet	tent to endorse checl	ks and di	rect the use	of the proceed	s thereof	? □ Yes □ No			
Functional capacity (American Heart Association):   Class 1 (No limitation)  Class 3 (Marked limitation)  Class 3 (Marked limitation)  Class 4 (Complete limitation)  VISUAL IMPAIRMENT  What was vision at last observation?  O.D.  O.S.  Month  Day  Year  With glasses										
Functional capacity (American Heart Association):   Class 1 (No limitation)  Class 3 (Marked limitation)  Class 3 (Marked limitation)  Class 4 (Complete limitation)  VISUAL IMPAIRMENT  What was vision at last observation?  O.D.  O.S.  Month  Day  Year  With glasses	CARDIAC							. *		
Blood pressure: Class 2 (Slight limitation)		American Heart Asso	ciation):	Class 1 (	No limitation)		Class 3 (Marked lin	nitation)		
VISUAL IMPAIRMENT What was vision at last observation?  O.D. O.S. Month Day Year With glasses			,							
What was vision at last observation?  O.D. O.S. Month Day Year With glasses						50				
With glasses										
With glasses		O.D.		O.S.	Month		Dav	Year		
Without glasses	With glasses		- > -				1			
	Without glasses									

35367b-1