



American General Life Insurance Company of Delaware

Wilmington, Delaware

American International Life Assurance Company of New York

New York, New York

The United States Life Insurance Company in the City of New York

New York, New York

Administrative Office: 3600 Route 66, P.O. Box 1580, Neptune, NJ 07754-1580

THE PATIENT IS RESPONSIBLE FOR THE COMPLETION OF THIS FORM WITHOUT EXPENSE TO THE COMPANY.

Name of Patient		Date of Birth	
Address	City	State	Zip Code
Employer Name		Policy Number	

HISTORY

When did symptoms first appear or accident happen? Month _____ Day _____ Year _____

Date patient was unable to work because of disability Month _____ Day _____ Year _____

Has patient ever had same or similar condition? Yes No If "Yes," state when and describe _____

Is condition due to injury or sickness arising out of patient's employment? Yes No Unknown

Names and addresses of other treating physicians

DIAGNOSIS

Diagnosis (including any complications) _____

Subjective symptoms _____

Objective findings (include current X-rays, EKGs, Laboratory Data and any clinical findings) _____

DATES OF TREATMENT

Date of first visit _____ Date of last visit _____ Frequency Weekly Monthly Other (Specify) _____

NATURE OF TREATMENT (including surgery and medications prescribed, if any)

PROGRESS

Patient has Recovered Improved Unchanged Retrogressed

Patient is Ambulatory House Confined Bed Confined Hospital Confined

HOSPITALIZATION

Has patient has been hospital confined? Yes No If Yes, hospital name _____

Address: _____ Confined from _____ through _____

CARDIAC (if applicable) Functional Capacity (American Heart Association)

Class 1 (No limitations) Class 2 (Slight limitation) Class 3 (Marked limitation) Class 4 (Complete limitation)

Blood Pressure (last reading) _____ / _____ as of _____ Date

PHYSICAL IMPAIRMENT (*as defined in Functional Dictionary of Occupational Titles)

- Class 1 - No limitation of functional capacity, capable of heavy work*No restrictions (0-10%)
- Class 2 - Medium manual activity*(15-30%)
- Class 3 - Slight limitation of functional capacity, capable of light work* (35-55%)
- Class 4 - Moderate limitation of functional capacity, capable of clerical/administrative (Sedentary*) activity (60-70%)
- Class 5 - Severe limitation of functional capacity, incapable of minimal (Sedentary*) activity (75-100%)
- Remarks _____

MENTAL/NERVOUS IMPAIRMENT (if applicable)

List the patient's DSM-IV Axes:

Axis I _____ Axis II _____ Axis III _____ Axis IV _____

List the patient's most recent GAF Score _____ Date of assessment _____ Highest GAF Score in the last year _____

Please fully describe the patient's limitations _____

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

PROGNOSIS

What are the patient's current restrictions and limitations? _____

<p>If none, when was patient able to resume work? Month _____ Day _____ Year _____</p> <p>Do you expect a fundamental or marked change in the future including improvement and/or deterioration? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>When will patient recover sufficiently to perform duties? <input type="checkbox"/> 1 Month <input type="checkbox"/> 1-3 Months <input type="checkbox"/> 3-6 Months <input type="checkbox"/> Indefinitely <input type="checkbox"/> Never</p>	<p>PATIENT'S JOB:</p> <p>ANY OTHER WORK:</p> <p>Month _____ Day _____ Year _____</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> 1 Month <input type="checkbox"/> 1-3 Months <input type="checkbox"/> 3-6 Months <input type="checkbox"/> Indefinitely <input type="checkbox"/> Never</p>
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REHABILITATION

Is patient a suitable candidate for further rehabilitation services? Yes No Explain under REMARKS. (i.e., cardiopulmonary program, speech therapy, etc.)

Would job modification enable patient to work with impairment? Yes No Explain under REMARKS.

Would vocational counseling and/or retraining be recommended? Yes No Explain under REMARKS.

REMARKS

THESE STATEMENTS ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

Name of Physician Completing This Form (Print)		Degree/Specialty	Tax ID Number	
Address		City	State	Zip Code
Telephone Number		Fax Number		
Signature				Date