StirlingBenefits™

DISABLED DEPENDENT ATTENDING PHYSICIAN'S STATEMENT

(Completed at Patient's Expense)

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PART A – TO BE COMPLETED BY PATIENT OR EMPLOYEE IF UNABLE TO COMPLETE OR UNDER 18

Full Name of Patient (Please Print)	Date of Birth	SSN
Address		
Name of Employer	Patient's Phone Number/Email	

I certify I am covered dependent who is totally disabled, unmarried, incapable of self-sustaining employment by reason of mental or physical handicap and primarily dependent upon the covered employee for support and maintenance.

Signature of Employee___________________________________ / Signature of Patient___________________________________

PART B – TO BE COMPLETED BY PHYSICIAN

1. DIAGNOSTIC INFORMATION

(a) Diagnosis ____

____

(b) Symptoms____

____

2. ASSESSMENT

(a) Describe the patient's current physical and mental limitations, and work activity restrictions____________________________

____

(b) How long will the described limitations impair the patient?____

____

3. TREATMENT

(a) Date of first visit___________________________ Date of last visit____

Frequency of visits: ☐ Weekly ☐ Monthly ☐ Other (Specify) ____

Hospital confinements: ☐ Yes ☐ No (If yes, give name and address of hospital)_____________________________________

____

b) Nature of treatment (include name and date of surgery, medication prescribed, and therapy, if any) ______________________

____

c) Anticipated duration of treatment (include surgery and therapy, if any) ____

____

4. PROGNOSIS

	OWN OCCUPATION	**ANY OCCUPATION**
Patient now totally disabled from:	☐ Yes ☐ No	☐ Yes ☐ No

When do you expect a fundamental or marked change in the patient's condition?
☐ Never ☐ Condition expected to regress ☐ Condition expected to improve

When do you anticipate the patient can return to work? ☐ 1-3 Mos ☐ 3-6 Mos ☐ Undetermined ☐ Never

REMARKS: ____

I hereby certify that the information I have given is true, correct, and complete to the best of my knowledge

Name of Physician (Print) _____________________________ Degree ____________________________ Phone ______________________

Address____

Signature ____ Date_______________________________