ATTENDING PHYSICIAN'S STATEMENT

This form is to be completed without expense to Lincoln Financial and returned along with your original claim for benefi ts or by the date requested by the Lincoln Financial Claims Dept.

Group Market Disability Claims
Liberty Life Assurance Company of Boston,
A Lincoln Financial Group Company
P.O. Box 7209
London, KY 40742-7209
Phone No.:1-800-838-4461
Fax No.: 1-877-664-7264

Return to: _____

PART A: TO BE COMPLETED BY EMPLOYEE

EMPLOYEE/CLAIMANT NAME: _____

CLAIM NO.: _____ S.S. NO.: ___ - ___ - ___

EMPLOYER/SPONSOR: UCI DATE OF BIRTH: _____

Authorization to Obtain and Release Information

I authorize any licensed physician, medical provider, hospital, medical facility, pharmacy, government agency, including the Social Security Administration and Veterans Administration, insurance or reinsurance company, credit or consumer reporting agency. financial/educational institutions and any current or former employer to release any and all of the following information to the particular Company in the Lincoln Financial Group of companies to which I am submitting a claim, or to its legal representative, or to the Plan Sponsor (if Self Insured Plan), or to persons or other organizations providing claims management services:

1. Medical information with respect to any physical or mental condition and/or treatment of me, including confidential information regarding AIDS/HIV infection, communicable diseases, alcohol and substance abuse, and mental health.

2. Information with respect to: job duties, earnings, employment applications, personnel records, and other work related information; records and information related to any insurance coverage and claims filed; credit information including, but not limited to, credit reports and credit applications; other financial information including bank records; complete copies of Federal and State tax returns: including attachments; and academic transcripts.

3. Information concerning Social Security benefits, including, but not limited to, monthly benefit amounts, monthly Supplemental Security Income payment amounts, entitlement dates, information from my Fact Query, and any benefits to which my dependents may be eligible under my record.

I understand the Company or Plan Sponsor will use the information obtained under this Authorization or directly from me to determine eligibility for insurance benefi ts, which may include assessing ongoing treatment. Any information obtained will not be released to any person or organizations EXCEPT to the Plan Sponsor, reinsuring companies, other companies in the Lincoln Financiall Group of companies to which I am submitting a claim, Employee Assistance Programs (EAP) or other disease management or __ assistance programs providing services to the Plan Sponsor and/or to the Company, persons or other organizations providing claims management and claim advisory services to the Plan Sponsor and/or to the Company, the Group Policyholder and its agents/vendors for purposes of auditing the Company's administration of the claims under the policy and/or assessing statistical claim data related to its benefi t programs, persons or organizations providing medical treatment or services in connection with my claim, or as may be otherwise permitted or required by law. I also understand that, to the extent reasonably necessary, information obtained may be released to other insurance companies or insurance support organizations to detect or prevent criminal activities, fraud, material misrepresentation, or material non-disclosure in connection with insurance transactions.

If I receive a disability benefit greater than which I should have been paid, I understand that the Company has the right to recover such overpayment from me, including the right to reduce future disability benefits, if any.

I understand that any person, who knowingly, and with intent to injure, defraud, or deceive the Company and/or Plan Sponsor, flies a statement or claim containing any false, incomplete, or misleading information may be guilty of a criminal act punishable under law.

I know that I may request a copy of this Authorization. I agree that a photographic copy of this Authorization shall be as valid as the original. This Authorization shall become effective on the date appearing next to my signature below. I understand that this Authorization shall be valid for two years from the date appearing below with my signature and that I have the right to revoke this Authorization at any time by notifying the Plan Sponsor and/or the Company in the Lincoln Financial group of companies to which I submit a claim..

_____ _____
Claimant's Signature (or Authorized Representative) Date

PART B: TO BE COMPLETED BY ATTENDING PHYSICIAN

PHYSICIAN'S INSTRUCTIONS

PLEASE NOTE: IF ANY PORTION OF THIS FORM IS NOT COMPLETED, WE WILL BE REQUIRED TO REQUEST THE INFORMATION WHICH WILL RESULT IN A DELAY IN DETERMINATION OF YOUR PATIENT'S DISABILITY BENEFITS.

THE CLINICAL INFORMATION, IN COMBINATION WITH THE PHYSICAL FACTORS OF YOUR PATIENT'S JOB AND THE CONTRACTUAL PROVISIONS UNDER WHICH HE/SHE IS COVERED, WILL BE USED TO ESTABLISH THE MOST APPROPRIATE WORK ABSENCE DURATION.

1. After you have completed this form, please attach copies of the following materials:

- **Office notes for the period of treatment**
- **Test Results showing medical evidence**
- **Hospital discharge summary (if applicable)**
- **Consulting physician's reports (if applicable)**

2. DIAGNOSIS

Primary _____ ICD9 _____
Secondary _____ ICD9 _____
_____ ICD9 _____

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

What is your prognosis?

PHYSICIAN, PLEASE COMPLETE THE REVERSE SIDE OF THIS FORM.

PART B, cont.: TO BE COMPLETED BY ATTENDING PHYSICIAN

3. DATES OF TREATMENT

(a) Date of First Visit _____ (mo/day/yr)
(b) Date of Last Visit _____ (mo/day/yr)
(c) Frequency of Visits ____ Weekly ____ Monthly ____ Other (specify)
(d) Date of First Treatment _____ (mo/day/yr)
(e) Date Symptoms First Appeared / Accident Occurred _____ (mo/day/yr)
(f) Date Patient Advised to Cease Work _____
(g) Estimated Return to Work Date _____

4A. Please describe in detail your PROPOSED TREATMENT PLAN.

4B. Please list all medications the patient is taking for this condition. Include your prognosis as a result of this treatment plan.

5. FOR THE NEXT SECTIONS (5A & 5B), PLEASE COMPLETE THE RESTRICTIONS/LIMITATIONS THAT ARE APPLICABLE TO YOUR PATIENT'S IMPAIRMENT

5A. Restrictions and/or Limitations for a Physical Impairment

Key - Occasionally	Frequently	Constantly
Up to 20 mins/hr	Up to 40 mins/hr	Over 40 mins/hr
Up to 2½ hrs/day	Up to 5½ hrs/day	Over 5½ hrs/day

____ Sedentary (lift/carry up to 10 pounds occasionally, sitting over 50% of the time and standing/walking occasionally.
____ Light (lift/carry up to 20 pounds occasionally, sitting at least occasionally and standing/walking frequently.
____ Medium (lift/carry up to 50 pounds occasionally, sitting, standing and/or walking constantly.
____ Heavy (life/carry up to 100 pounds occasionally, sitting, standing and/or walking constantly.
____ Very Heavy (lift/carry over 100 pounds, occasionally, sitting, standing and/or walking constantly.

Release to Return to work date _____ If no, expected release to return to work _____
If there are any other physical restrictions/limitations such as bending/stooping/reaching please specify_____
_____
_____
_____

5B . Restrictions/Limitations for a Psychiatric Impairment (The following questions are directed toward a determination of your patient's ability to perform various functions. Please indicate the degree of restrictions. Any items which you do not believe you can answer should be marked "N/A".)

General	**None**	**Mild**	**Moderate**	**Significant**
Interpersonal Relations	_____	_____	_____	_____
Daily Activities: Occupational/Social	_____	_____	_____	_____
Personal Habits: Appearance/Behavior	_____	_____	_____	_____
Constriction of Interests	_____	_____	_____	_____
Work-Related				
Ability to Think and Reason	_____	_____	_____	_____
Understand and Carry out Instructions	_____	_____	_____	_____
Sustain Work Performance	_____	_____	_____	_____
Attention Span	_____	_____	_____	_____
Cope with Work Pressure	_____	_____	_____	_____
Mental Status				
Concentration	_____	_____	_____	_____
Past/Present Memory	_____	_____	_____	_____
Insight and Judgment	_____	_____	_____	_____

Comments (In view of this assessment, please add any further comments which would assist us in our understanding of specific limitations and restrictions.)
_____
_____
_____

6. CARDIAC IMPAIRMENT (if applicable)

Functional Capacity: ____ Class 1: No Limitation ____ Class 2: Slight Limitation
(per American Heart Assn) ____ Class 3: Marked Limitation ____ Class 4: Complete Limitation
Blood Pressure (last visit): _____ (systolic/diastolic)

7. Date of Next Scheduled Visit

Are you still treating the patient? ____ Yes ____ No
If patient has been referred to another physician, please indicate the name of physician, address, telephone number, and reason for referral.

Was patient referred to you by another physician? ____ Yes ____ No

8. Has patient been hospital confined? ____ Yes ____ No
Dates of Confinement: From _____ to _____
Was surgery performed? ____ Yes ____ No If "Yes", please indicate procedure(s) performed:
CPT Code: _____ Date Performed _____
Name and Address of Hospital:

9. REMARKS

Attending Physician's Name (PLEASE PRINT)	Degree/Specialty	SS No. or Tax ID No.
Street Address	( ) Telephone No.	( ) Fax No.
City/State/Zip Code	Signature	Date