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.

Contract number	Division/location	Employee's name

Social Security number	Employee's home address

Date of birth	Sex	❒ Married ❒ Divorced ❒ Single ❒ Widowed	Date employed	Occupation

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? Month _____ Day _____, 19 ____

Date patient ceased work because of disability: Month _____ Day _____, 19 ____

Has patient ever had same or similar conditions? ❒ Yes ❒ No

PRESENT CONDITION

Subjective symptoms	Objective findings

DIAGNOSIS

PROGNOSIS

TREATMENT

Date of visit? Month _____ Day _____, 19 ____

Date of last visit? Month _____ Day _____, 19 ____

Frequency of visits: ❒ Weekly ❒ Monthly ❒ Other

When did you actually examine the patient? Month _____ Day _____, 19 ____

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.) ❒ Yes ❒ No
2. If the disability is not considered total and permanent, do you anticipate a release to his own occupation? ❒ Yes ❒ No
   (If "yes," when? _____)
3. If you answered "no," do you anticipate a release to a less physically and/or emotionally demanding occupation? ❒ Yes ❒ No
   (If "yes," when? _____)
4. If the employee cannot perform the duties of his own occupation, would you feel it appropriate to consider VOCATIONAL 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) ❒ Class 2 (Slight limitation) ❒ Class 4 (Complete limitation)

Blood pressure: _____

VISUAL IMPAIRMENT

What was vision at last observation?

	O.D.	O.S.	Month	Day	Year
With glasses					
Without glasses					