CNA GROUP BENEFITS Continental Casualty Company

P O BOX 946790
Maitland, Fl 32794-6790

STATEMENT OF PHYSICIAN

APPLICATION FOR ACCIDENTAL PERMANENT TOTAL DISABILITY INDEMNITY

PATIENT: ______________________________

PATIENT'S DATE OF BIRTH: ______________________________

CLAIM NO: ______________________________

1. WHAT IS/ARE THE CONDITION(S) THAT PRESENTLY DISABLE(S) YOUR PATIENT, INCLUDING CONCURRENT CONDITIONS?

2. WHEN DID THE SYMPTOMS FIRST APPEAR OR THE ACCIDENT HAPPEN?

3. WHEN DID THE PATIENT FIRST CONSULT YOU FOR THIS/THESE CONDITION(S)?

4. NAMES AND ADDRESSES OF OTHER PHYSICIANS TREATING THE PATIENT:

5. HAS THE PATIENT EVER HAD THE SAME OR A SIMILAR CONDITION?
   YES ( ) NO ( ) IF YES, STATE WHEN AND DESCRIBE:

6. STATE THE ACTUAL CAUSE TOGETHER WITH A BRIEF RESUME' OF THE HISTORY OR COURSE OF TREATMENT OF EACH CONDITION.

7. LIST THE DATES OF TREATMENT OR THE APPROXIMATE FREQUENCY.

8. NATURE OF ANY SURGICAL PROCEDURES PERFORMED AND THE DATE?

   STILL UNDER YOUR CARE? YES ( ) NO ( )

9. IS THE PATIENT TOTALLY OR PARTIALLY DISABLED?

   WHAT PHYSICAL LIMITATIONS HAVE BEEN IMPOSED UPON THE PATIENT BY EACH CONDITION AND/OR BY YOU?

   IN WHAT WAY IS THE PATIENT PREVENTED FROM ENGAGING IN A SUITABLE, GAINFUL OCCUPATION?

10. HAS THE PATIENT BEEN HOUSE CONFINED? YES ( ) NO ( )
IF YES, TO WHAT EXTENT?

11. TO WHAT DEGREE DOES THE PATIENT'S INJURY CONTRIBUTE TO OR CAUSE THE PRESENT STATE OF DISABILITY? HAVE ANY COMPLICATIONS EXTENDED THE CURRENT PERIOD OF DISABILITY? PLEASE ELABORATE.

12. BEARING IN MIND THE AGE, EDUCATION, TRAINING AND EXPERIENCE BACKGROUND OF THE PATIENT AND HIS PRESENT PHYSICAL LIMITATIONS, IS IT POSSIBLE FOR HIM TO ENGAGE IN A SUITABLE, GAINFUL EMPLOYMENT FOR WAGE OR PROFIT? ( ) Yes ( ) No IF SO, WHAT TYPE OF EMPLOYMENT WOULD BE SUITABLE?

    TO WHAT EXTENT WOULD THE PATIENT BE CAPABLE OF PERFORMING SUCH EMPLOYMENT ON A FULL-TIME BASIS?
    ON A PART-TIME BASIS?

13. WHAT ARE THE PRESENT PLANS IN REGARD TO HIS FUTURE MEDICAL TREATMENT? ANY PLANS FOR REHABILITATION FOR EMPLOYMENT? PROGNOSIS?

14. DO YOU CONSIDER THIS PATIENT PERMANENTLY AND TOTALLY DISABLED? PLEASE ELABORATE.

15. WHEN DID HE FIRST BECOME PERMANENTLY AND TOTALLY DISABLED?

REMARKS OR COMMENTS:

SIGNATURE: ______________________________

PRINT NAME: ______________________________

ADDRESS: ______________________________

CITY AND STATE: ______________________________

TELEPHONE NO: ______________________________

TODAY'S DATE: ______________________________

RETURN TO: GARDNER & WHITE
INSURED CLAIMS DEPT.
P.O. BOX 40948
INDPLS, IN 46240-0948