

Attending Physician's Statement

The United States Life Insurance Company in the City of New York
American General Assurance Company
Member of American International Group, Inc.
Schaumburg, IL
New York, New York

*American General Assurance Company is not admitted in New York

AS REQUIRED BY LAW, ANY PERSON WHO KNOWINGLY AND WITH INTENT TO FRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR A STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND FOR OCCURRENCES IN THE STATE OF NEW YORK, SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

The patient is responsible for the completion of this form without expense to the Company

Name of Patient _____ Date of Birth _____

Address _____

Employer Name _____ Policy No. _____

1. HISTORY

- (a) When did symptoms first appear or accident happen? Mo. _____ Day _____ Year _____
(b) Date patient ceased work because of disability Mo. _____ Day _____ Year _____
(c) Has patient ever had same or similar condition? Yes No If "Yes," state when and describe
(d) Is condition due to injury or sickness arising out of patient's employment? Yes No Unknown
(e) Names and addresses of other treating physicians

2. DIAGNOSIS (including any complications)

- (a) Date of last examination Mo. _____ Day _____ Year _____
(b) Diagnosis (including any complications)
(c) Subjective symptoms
(d) Objective findings (including current X-rays, EKGs, Laboratory Data and any clinical findings)

3. DATES OF TREATMENT

- (a) Date of first visit Mo. _____ Day _____ Year _____ (b) Date of last visit Mo. _____ Day _____ Year _____
(c) Frequency Weekly Monthly Other (Specify)

4. NATURE OF TREATMENT (including Surgery and medications prescribed, if any)

5. PROGRESS

- (a) Has patient..... Recovered? Improved? Unchanged? Retrogressed?
(b) Is patient..... Ambulatory? House Confined? Bed Confined? Hospital Confined?
(c) Has patient been hospital confined? Yes No If "Yes," give Name and Address of Hospital Confined from _____ through _____

6. CARDIAC (if applicable)

- (a) Functional Capacity Class 1 (No limitation) Class 2 (Slight limitation) Class 3 (Marked limitation) Class 4 (Complete limitation)
(b) Blood Pressure (last visit) SYSTOLIC DIASTOLIC

7. 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%)

8. MENTAL/NERVOUS IMPAIRMENT (if applicable)

- (a) Please define "stress" as it applies to this claimant.
(b) What stress and problems in interpersonal relations has claimant had on job?
Class 1 - Patient is able to function under stress and engage in interpersonal relations (no limitations)
Class 2 - Patient is able to function in most stress situations and engage in most interpersonal relations (slight limitations)
Class 3 - Patient is able to engage only in limited stress situations and engage in only limited interpersonal relations (moderate limitations)
Class 4 - Patient is unable to engage in stress situations or engage in interpersonal relations (marked limitations)
Class 5 - Patient has significant loss of psychological, physiological, personal and social adjustment (Severe limitations)
Remarks

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

9. PROGNOSIS

- (a) Is patient now totally disabled for patient's job? Yes No
(b) Is patient now totally disabled for any other job? Yes No
(c) If not now totally disabled, when was patient able to resume work?
(d) Do you expect a fundamental or marked change in the future?
(1) If yes, when will patient recover sufficiently to perform duties?
(2) If no, please explain?

PATIENT'S JOB: Full-time Part-time
Mo. / Day / Year
Yes No
Mo. / Day / Year
1 mo. 3-6 mo.
1-3 mo. Never

ANY OTHER WORK: Full-time Part-time
Mo. / Day / Year
Yes No
Mo. / Day / Year
1 mo. 3-6 mo.
1-3 mo. Never

10. REHABILITATION

- (a) Is patient a suitable candidate for further rehabilitation services? Yes No
(i.e., cardiopulmonary program, speech therapy, etc.)
(b) Would job modification enable patient to work with impairment? Yes No If "Yes," explain
(c) When could trial employment commence?
(d) Would vocational counseling and/or retraining be recommended? Yes No

PATIENT'S JOB: Full-time Part-time
Mo. / Day / Year

ANY OTHER WORK: Full-time Part-time
Mo. / Day / Year

11. Are you aware of any other disability income policies? Yes No
Insurance company name(s) _____ Policy number(s) _____

NAME (ATTENDING PHYSICIAN) PLEASE PRINT DEGREE/SPECIALTY TELEPHONE

STREET ADDRESS CITY OR TOWN STATE OR PROVINCE ZIP CODE OR POSTAL