



## ATTENDING PHYSICIAN'S STATEMENT (APS)

**\*\* Neither the Employee nor the Employer should complete or alter any part of the APS. \*\***

Patient's Full Name _____	Date of Birth _____
Diagnosis & Concurrent Conditions 1. _____ 2. _____	ICD Codes 1. _____ 2. _____
Disability is due to <input type="checkbox"/> Accident <input type="checkbox"/> Sickness <input type="checkbox"/> Pregnancy If accident, provide how, when and where accident occurred _____ _____ _____ If Pregnancy, _____ <input type="checkbox"/> Actual <input type="checkbox"/> Estimated Delivery Date _____ Type of Delivery <input type="checkbox"/> Vaginal <input type="checkbox"/> C-section _____ Date Symptoms First Appeared _____ Date Patient First Consulted You _____ Dates & Surgical Procedures (if any) _____ _____ If hospitalized, <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient Date Admitted _____ Date Discharged _____ Full Name of Hospital _____ Address _____ City, State, Zip Code _____ _____ Telephone # of Hospital _____	Did disability arise from patient's employment? <input type="checkbox"/> Yes <input type="checkbox"/> No _____ How long was or will patient be unable to work due to disability? From _____ Through _____ Can return to work on _____ Please list all treatment dates during the month in which the disability began _____ _____ _____ Date of next doctor's appointment _____ _____ List Restrictions and Limitations _____ _____ _____ _____ Has patient ever had same or similar condition? <input type="checkbox"/> No <input type="checkbox"/> Yes    Date _____ Describe any circumstances causing disability to be prolonged: _____ _____ _____

Physician's Signature _____	Date _____
Physician's Name (Please Print/Type) _____	Degree _____
Address _____	Telephone _____
City _____ State _____ Zip Code _____	Fax _____

**FRAUD WARNING: Except as noted in separate Fraud Notice, it is or may be a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company or other person. Penalties may include imprisonment, fines, and denial of insurance benefits in accordance with applicable state law.**

### EMPLOYER'S STATEMENT

Group Policy Number _____	Employee Social Security No. _____	Date of Hire _____	Coverage Effective Date _____	Weekly STD Benefit \$ _____
Last Day Worked Date _____ # of Hours _____	Date Returned to Work <input type="checkbox"/> Full-Time _____ <input type="checkbox"/> Part-Time _____	Base Salary \$ _____ <input type="checkbox"/> Hourly <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Annually	Employee Regularly Works _____ Hours Per Week Employee Regularly Works Weekends? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Has a Workers' Compensation claim been filed or is a claim expected to be filed for this disability? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Employee received:    Salary continuation through _____    Vacation pay through _____    Sick pay through _____				
Employer Name _____				Tax ID # _____
Signature _____		Title _____	Date _____	
Name (Please print or Type) _____		Telephone _____	Fax _____	
Street Address _____		City _____	State _____	Zip Code _____

## **FRAUD NOTICE**

For your protection, the laws of some states may require us to furnish you with the following notice:

Except as otherwise noted below, it is or may be a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company or other person. Penalties may include imprisonment, fines, and denial of insurance benefits in accordance with applicable state law.

### **Arizona**

Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

### **California**

Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

### **Colorado**

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

### **Florida**

Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

### **New Jersey**

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

### **Pennsylvania**

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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 subjects such person to criminal and civil penalties.

Retain for your records.