

This form should be completed by all physicians who were treating the claimant during the time of disability. The patient is responsible for the completion of this form without expense to Assurity Life. Please print or type. If necessary add a separate sheet. Direct any questions to our claims department at the phone numbers shown above.

A. General Information

Patient's Name (First, Middle, Last)	Policy No.	Date of Birth (MM/DD/YYYY)
[Redacted]		

Primary Diagnosis including ICD 9 or DSM Code

[Redacted]		
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B. Complete this section for all conditions

Symptoms		
[Redacted]		

Objective Findings

[Redacted]		
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Are there secondary conditions contributing to the patient's inability to work? Yes No If YES, what are they?

When did symptoms first appear? initial visit 11/27/24	Date of patient's first visit (MM/DD/YYYY) 11/27/2024	Date of the patient's last visit (MM/DD/YYYY) 02/11/2025
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How often do you treat/consult the patient?
Every 2 weeks until 35wks and then weekly

Date you believe the patient was first unable to work (MM/DD/YYYY) 12/27/2024
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Was patient referred to you? Referring physician's name

Street address

City

State

Zip+4

 Yes NoIs the patient's condition work related? Yes No If YES, please explain:

Has the patient undergone surgery? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If YES, please give date, procedure and result: 12/29/2024 C-Section
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If no, do you expect surgery to be performed in the future? Yes No If YES, please give date and type of surgery:

What medications is the patient currently taking? (Please list frequency and dosages.)
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Please indicate other types and frequencies of treatment:

Has the patient been referred to a medical rehabilitation or therapy program? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If YES, please give details:
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Have you referred the patient for other types of consultations? Yes No If YES, please give details:

Has the patient been hospital confined? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If YES, complete the following:

Name of hospital [Redacted]	Street address [Redacted]	City [Redacted]	State [Redacted]	Zip+4 [Redacted]
MM/DD/YYYY 12/27/24	MM/DD/YYYY 1/11/25	Admission time	Dismissal time	

Confined: 12/27/24 through 1/11/25 Admission time Dismissal time Continue to page 2 of this form.

Policy/Certificate no.(s) 45519875Claimant's Name [REDACTED]

Indicate class of mental impairment (<i>if applicable</i>): <input type="checkbox"/> Class 1-No limitation <input type="checkbox"/> Class 2-Slight limitation <input type="checkbox"/> Class 3-Moderate limitation <input type="checkbox"/> Class 4-Marked limitation <input type="checkbox"/> Class 5-Severe limitation			
What is the patient's current DSM-IV-R diagnosis? <input type="checkbox"/> Axis I _____ <input type="checkbox"/> Axis II _____ <input type="checkbox"/> Axis III _____ <input type="checkbox"/> Axis IV _____ <input type="checkbox"/> Axis V _____			
Do you believe this patient is competent to endorse checks/direct the use of proceeds? <input type="checkbox"/> Yes <input type="checkbox"/> No			
C. Complete this section for pregnancy			
Date of the last menstrual period <u>4/12/2024</u>	MM/DD/YYYY	First date of treatment <u>11/27/2024</u>	MM/DD/YYYY
Expected due date <u>01/17/25</u>	MM/DD/YYYY		
Date of delivery <u>12/09/25</u> (MM/DD/YYYY)	This delivery is expected to be or was: <input type="checkbox"/> Vaginal <input checked="" type="checkbox"/> C-Section		
Are there any present complications or anticipated difficulties in connection with: a. Pregnancy <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No b. Delivery <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No c. Post partum <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
If YES, to any of the above, please specify in detail: <u>Post partum wound infection.</u>			
D. Information about the patient's inability to work. Complete this section for all conditions.			
Briefly describe restrictions (<i>What the patient SHOULD NOT do</i>): <u>Pt is unable to work 6 weeks following delivery</u>			
Briefly describe limitations (<i>What the patient CANNOT do</i>): <u>Patient is unable to work 6 weeks following delivery</u>			
When was/is the patient able to return to work? Full-time <u>02/17/2025</u> (MM/DD/YYYY)	Part-time <u>/ /</u> (MM/DD/YYYY)		
Does the patient's condition prevent being able to perform self care? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If NO, please complete the following: How soon do you expect fundamental changes in the patient's medical condition? <input checked="" type="checkbox"/> 1-2 mos. <input type="checkbox"/> 3-4 mos. <input type="checkbox"/> 5-6 mos. <input type="checkbox"/> 6+ mos.			
Give details concerning expected improvement or deterioration:			
Additional remarks:			
E. Physician Information			
Attending physician, please print Physician's name <u>[REDACTED]</u>		Degree <u>OB/GYN</u>	
Phone no. <u>()</u>	Street address <u>[REDACTED]</u>	City <u>[REDACTED]</u>	State <u>MS</u> Zip+4 <u>39232</u>
Physician's address <u>[REDACTED]</u>			
F. Fraud Notices			
Unless specific state language is provided below for your state of residence, the following general fraud notice applies.			
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 shall also be subject to a substantial civil penalty where and to the extent allowed by state law.			
AL RESIDENTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or who knowingly presents false information in an application for insurance, is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.			
AR, DC, LA, MA, RI RESIDENTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance, is guilty of a crime and may be subject to fines and confinement in prison.			
AZ RESIDENTS: For your protection, Arizona law requires the following statement to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.			

Continue to page 3 of this form.

F. Fraud Notices (continued)

CA RESIDENTS: For your protection, California law requires the following to appear on this form: 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.

CO RESIDENTS: 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.

FL RESIDENTS: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

IL RESIDENTS: 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 fraud or intentional misstatements of material fact commits a fraudulent insurance act, which is a crime and subject to a substantial civil penalty where and to the extent allowed by state law.

KS RESIDENTS: 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 may be a crime as determined by a court of law and shall also be subject to a substantial civil penalty where and to the extent allowed by state law.

KY RESIDENTS: Any person who knowingly and with intent to defraud any insurance company or other person, files 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.

MD RESIDENTS: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit, or who knowingly or willfully presents false information in an application for insurance, is guilty of a crime and may be subject to fines and confinement in prison.

ME, TN, WA RESIDENTS: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

MN RESIDENTS: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NC RESIDENTS: 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 may also be subject to a substantial civil penalty where and to the extent allowed by state law.

NH RESIDENTS: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information, is subject to prosecution and punishment for insurance fraud.

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

NM RESIDENTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance, is guilty of a crime and may be subject to civil fines and criminal penalties.

NY RESIDENTS: 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 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.

OH RESIDENTS: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

OK RESIDENTS: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

OR RESIDENTS: Any person who knowingly and with intent to defraud an insurance company or any other person presents a false claim for payment of a loss or benefit may be guilty of insurance fraud and subject to civil fines and criminal penalties. If such misinformation is material to the content of the contract, relied upon by the insurer and either material to the risk assumed by the insurer or provided fraudulently, such action may also lead to denial of insurance benefits.

PA RESIDENTS: 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.

VA RESIDENTS: Any person who, with the intent to defraud or knowing that they are facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

VT RESIDENTS: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

I hereby acknowledge that I have read the applicable fraud notice above.

I hereby certify the statements above are complete and accurate to the best of my knowledge.

Physician's Signature (no stamp)

1/15/2025

Date (MM/DD/YYYY)

TIN or Social Security No.

From: [REDACTED]
Posted At: 1/15/2025 3:59:27 PM
Posted To: [REDACTED]
Subject: Fax Received: 6622706204

Delivery Information:

Message #: 329882
Remote CSID: MM01570@msn.com
Total Pages: 3
Receive Time: 1/15/2025 2:59:16 PM
Transmit Time: 2 min : 21 sec

