Disability Insurance Benefits
Physician's Statement

Patient Information

Patient Name: [_____]

Date of Birth: [_____]

Policy Number: [_____]

Medical Information

Diagnosis:

[_____]

Symptoms:

[_____]

Treatment Plan:

[_____]

Date Disability Began: [_____]

Expected Return to Work Date: [_____]

Physician Information

Physician Name: [_____]

Specialty: [_____]

Contact Number: [_____]

Physician Signature: [_____]

Date: [_____]

[Submit]