



Principal Life Insurance Company
 Attn: Group Life and Disability Claims Department
 Des Moines, Iowa 50392-0002
 Call: 1-800-245-1522 Fax: 1-800-255-6609
 Email: DLSBDCLAIMS@EXCHANGE.PRINCIPAL.COM

Attending Physician's Statement

Attending Physician Statement - To be completed by your Physician – Include office notes and test results from date of disability to present

The following information is needed to document the patient's inability to work. The patient is responsible for obtaining a complete form without expense to Principal. Please complete this form and mail or fax it to Principal using the contact information listed above.

| | | | | |
|----|---|--------------------|---|------------------|
| 1 | Patients Name: | Date of Birth: | | |
| 2 | Social Security #: | Height: | Weight: | |
| 3 | Patient is/was unable to work due to : Injury <input type="checkbox"/> Illness <input type="checkbox"/> Pregnancy <input type="checkbox"/> | | If pregnancy , Skip to question 19 | |
| 4 | List all ICD-10 Diagnosis Code(s): | | | |
| 5 | List any complications your patient is experiencing: | | | |
| 6 | Objective Findings (X-rays, EKG's, MRI results, lab data and clinical findings) | | | |
| 7 | Subjective Symptoms | | | |
| 8 | Please provide date symptoms first appeared or accident happened? _____ | | | |
| 9 | Is the condition due to injury or illness arising from of your patient's employment? Yes <input type="checkbox"/> No <input type="checkbox"/> | | | |
| 10 | Did this condition already exist and become exacerbated by employment? Yes <input type="checkbox"/> No <input type="checkbox"/> | | | |
| | If yes, please explain: _____ | | | |
| 11 | Is patient competent to endorse checks and direct the use of those proceeds? Yes <input type="checkbox"/> No <input type="checkbox"/> | | | |
| 12 | Date of first visit | 13 | Date of last visit | 14 |
| | | | Date of next visit | 15 |
| | | | Frequency of visits | |
| 16 | Has your patient been hospitalized? Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, From date: _____ To date: _____ | | | |
| | Hospital Name: _____ Phone Number: _____ | | | |
| 17 | Has your patient ever had the same or similar condition? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, when _____ | | | |
| 18 | NATURE OF TREATMENT – Please specify all surgeries, medications AND dosage, therapy, and/or referrals. | | | |
| | Date of Surgery _____ Type of surgery _____ CPT-4 Codes _____ | | | |
| | If the patient was referred to you or by you to another physician list the Physician's name, address and phone number of the Physician: | | | |
| 19 | PREGNANCY SUBMISSIONS ONLY | | | |
| | What is the expected date of delivery? | Date first treated | Date last treated | Date of delivery |
| | Bed confined? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, Date From: _____ To: _____ Type of delivery: Vaginal <input type="checkbox"/> C-Section <input type="checkbox"/> | | | |
| | If complications are present prior to delivery, what complications is your patient experiencing? | | | |

20 PHYSICAL IMPAIRMENT

After discussing job duties with your patient, please provide the specific restrictions and limitations you have placed on your patient in the space provided below:

| | CONTINUOUSLY (2/3 + of time) | FREQUENTLY (1/3 – 2/3 of time) | OCCASIONALLY (Up to 1/3 of time) | NEVER |
|----------------------------------|---------------------------------|-----------------------------------|-------------------------------------|--------------------------|
| Sit | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Stand | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Walk | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Lift/Carry | lbs. | lbs. | lbs. | lbs. |
| Power Grasp | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Fine Manipulation | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Push/Pull | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Keyboarding | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Reach above shoulder level | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Reach at waist level/below waist | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Bend/Twist/Squat | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Climb/Balance | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

21 PROGNOSIS:

Date you recommended your patient to stop working? _____

How long do you expect these limitations and restrictions to impair your patient? Date: _____ Permanently

Unable to determine, follow-up in ____ weeks Do you support return to work with the limitations listed above at this time? Yes No

Do you support return to work on a part time basis? Yes No If yes, how many hours per day?

22 Physician Name (Please Print) _____ Degree _____

Specialty _____ Phone Number _____ FAX Number _____

Address _____ City _____ State _____ Zip Code _____

Tax ID Number: _____ NPI Number: _____

I certify the answers I have made to the above questions are complete and true to the best of my knowledge and belief.

Signature (No Stamp) X _____ Date: _____