



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: _____