Nassau Life and Annuity Company (the Company)
Nassau Life Insurance Company (the Company)
PHL Variable Insurance Company (the Company)
Nassau Life and Annuity Insurance Company (the Company)
PO Box 22012, Albany, NY 12201-2012
Phone: 800-814-3692
Fax: 321-400-6320

Supplemental Attending Physician's Statement

This form is to be completed without expense to the Company

CLAIMANT INFORMATION

First Name:_____ Last Name: _____

Date of Birth: _____ Home Phone: _____ Gender: ☐ Male ☐ Female

Address: _____

City: _____ State: _____ Zip: _____

Claim Number: _____ Policy Number: _____

Email: _____

PHYSICIAN'S INSTRUCTIONS

PLEASE NOTE: *IF ANY PORTION OF THIS FORM IS NOT COMPLETED, WE WILL BE REQUIRED TO REQUEST THE INFORMATION WHICH WILL RESULT IN A DELAY IN THE DETERMINATION OF YOUR PATIENT'S BENEFIT*

DIAGNOSIS (This section is required)

Primary Diagnosis: _____ ICD10: _____

Secondary Diagnosis: _____ ICD10: _____

Subjective Symptoms: _____

_____

Physician's Examination Findings:

Has the patient had any test results (list all clinical findings, including x-rays, ERG's, and lab tests):

Test: _____ Date: _____ Results: _____

Test: _____ Date: _____ Results: _____

Objective Signs:

Date Symptoms First Appeared/Accident Occurred: _____ Date Disability Began: _____

Has patient ever had the same or similar condition? ☐ Yes ☐ No If Yes, state when and describe:

_____

What are the current symptoms which support the above diagnosis? _____

_____

Name: _____ Claim #: _____ Policy #: _____

TREATMENT

Date of onset of this condition: _____ Date you first treated this patient for this condition: _____

Date of most recent visit: _____ Date of next office visit: _____

Frequency of Visits: ☐ Weekly ☐ Monthly ☐ Other: _____

Was the patient referred to you by another physician? ☐ Yes ☐ No
If Yes, provide name, address, phone number, and fax number: _____

_____

Have you referred this patient to any other physician? ☐ Yes ☐ No Date(s): _____

Physician Name: _____ Specialty: _____

Address: _____

City: _____ State: _____ Zip: _____

Frequency of current visits: ☐ Weekly ☐ Monthly ☐ Other (specify): _____

Medications (include name/dosage): _____

Therapy Prescribed: ☐ Physical ☐ Occupational ☐ Speech Frequency: _____

Is patient compliant with therapy? ☐ Yes ☐ No Tolerance to Therapy: ☐ Good ☐ Poor

Has surgery been performed? ☐ Yes ☐ No If Yes, date(s): _____

Procedure: _____

Was patient hospitalized for this condition? ☐ Yes ☐ No If Yes, date(s) admitted: _____

Name and Address of the Hospital: _____

Progress (please check one): ☐ Recovered ☐ Improved ☐ Unchanged ☐ Retrogressed

Patient is currently: ☐ Ambulatory ☐ Bed Confined ☐ House Confined ☐ Hospital Confined
☐ Nursing Home/Assisted Living Confined ☐ Wheelchair Confined

LEVEL OF FUNCTIONAL IMPAIRMENT (This section is required)

Do you advise patient to

a) reduce work hours? ☐ Yes ☐ No If Yes, as of what date? _____

b) continue to cease work? ☐ Yes ☐ No If Yes, as of what date? _____

c) return to work light duty? ☐ Yes ☐ No If Yes, as of what date? _____

When did you last examine the patient? _____

Name: _____ Claim #: _____ Policy #: _____

Have you identified any restrictions you have imposed on your patient as this time? ☐ Yes ☐ No
If Yes, please explain and identify durations:

_____

_____

_____

_____

Is the patient currently in a lower level of care (e.g. outpatient treatment), could he/she resume some/all work duties while continuing with treatment? ☐ Yes ☐ No If Yes, please explain:

_____

_____

_____

_____

Do you believe that this patient is competent to endorse checks and direct the use of the proceeds? ☐ Yes ☐ No
If Yes, please explain:

_____

_____

_____

_____

CARDIAC IMPAIRMENT (If applicable)

Functional Capacity:
(Per American Heart Association)

☐ Class 1: No Limitations ☐ Class 2: Slight Limitation
☐ Class 3: Marked Limitation ☐ Class 4: Compete Limitation

Blood Pressure (last visit Reading): _____ Date of Reading: _____

Name: _____ Claim #: _____ Policy #: _____

VISUAL IMPAIRMENT (If applicable)

What was vision at last observation? (Snellen Notation)

With glasses O.D.: _____ O.S.: _____ Date: _____

Without glasses O.D.: _____ O.S.: _____ Date: _____

Date corrected vision was irrecoverably reduced to 20/20 or less in the better eye: _____

Vision can be restored in whole or in part by:

O.D. ☐ Lenses ☐ Treatment ☐ Operation ☐ Not Restorable
O.S. ☐ Lenses ☐ Treatment ☐ Operation ☐ Not Restorable

Near Vision: ☐ Yes ☐ No Far Vision: ☐ Yes ☐ No
Depth Perception: ☐ Yes ☐ No Color Vision: ☐ Yes ☐ No

HEARING IMPAIRMENT (If applicable)

Test: _____ Date: _____

Results are: ☐ With Hearing Aids ☐ Without Hearing Aids

DEGREE OF HEARING LOSS:

Left: ☐ Normal ☐ Slight ☐ Moderate ☐ Moderately Severe ☐ Profound Date: _____

Right: ☐ Normal ☐ Slight ☐ Moderate ☐ Moderately Severe ☐ Profound Date: _____

Hearing can be restored in whole or in part by: ☐ Hearing Aids ☐ Treatment ☐ Operation ☐ Not Restorable

Please provide details to response above: _____

_____

Date corrected hearing was irrecoverably lost: Left Ear: _____ Right Ear: _____

Name: _____ Claim #: _____ Policy #: _____

PHYSICAL CAPACITIES EVALUATION (Stand, walk, sit, and drive is required)

In a work day, patient can stand:

(Hours at one time)
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

(Total hours during the day)
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

In a work day, patient can walk:

(Hours at one time)
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

(Total hours during the day)
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

In a work day, patient can sit:

(Hours at one time)
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

(Total hours during the day)
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

In a work day, patient can drive:

(Hours at one time)
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

(Total hours during the day)
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Patient can lift:	Never	Occassionally (Up to 33%)	Frequently (34% - 66%)	Continuously (67% - 100%)
<1 lb	☐	☐	☐	☐
1-10 lbs	☐	☐	☐	☐
11-20 lbs	☐	☐	☐	☐
21-30 lbs	☐	☐	☐	☐
31-40 lbs	☐	☐	☐	☐
41-50 lbs	☐	☐	☐	☐
51-100 lbs	☐	☐	☐	☐
>100 lbs	☐	☐	☐	☐

Patient can carry:	Never	Occassionally (Up to 33%)	Frequently (34% - 66%)	Continuously (67% - 100%)
≤10 lb	☐	☐	☐	☐
11-20 lbs	☐	☐	☐	☐
21-50 lbs	☐	☐	☐	☐

Patient can:	Never	Occassionally (Up to 33%)	Frequently (34% - 66%)	Continuously (67% - 100%)
Bend/Twist at Waist	☐	☐	☐	☐
Bend/Twist at Neck	☐	☐	☐	☐
Squat	☐	☐	☐	☐
Crawl	☐	☐	☐	☐
Climb	☐	☐	☐	☐
Balance	☐	☐	☐	☐
Reach (at or below shoulders)	☐	☐	☐	☐
Reach (at or above shoulders)	☐	☐	☐	☐
Computer Keyboarding	☐	☐	☐	☐
Mouse Usage	☐	☐	☐	☐

Name: _____ Claim #: _____ Policy #: _____

HANDLING RESTRICTIONS:

☐ Light ☐ Medium ☐ Heavy Dominant Hand: ☐ Right ☐ Left

	Hand Use	Simple Grasping	Fine Manipulation	Pushing and Pulling	Power Grasp
Left:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Right:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Remarks:

PHYSICIAN INFORMATION AND SIGNATURE

Attending Physician Name (Please print): _____

Degree: _____

Tax ID Number: _____ Phone: _____ Fax: _____

Address: _____

City: _____ State: _____ Zip: _____

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

Attending Physician Signature: _____ Date: _____

FRAUD STATEMENT

For Residents of Alaska and Oregon: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under state law.

For Residents of Arizona: 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.

For Residents of California: For your protection, California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

For Residents of 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.

For Residents of Delaware, Idaho, Indiana, and Oklahoma: 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.

For Residents of District of Columbia: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding an insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

For Residents of Florida: 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.

For Residents of Kentucky and 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.

For Residents of Maine, Tennessee, Virginia, and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

For Residents of Maryland, Rhode Island and West Virginia: 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.

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

For Residents of New Hampshire: 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, as provided in RSA 638:20.

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

For Residents of New Mexico: 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.

For Residents of Ohio: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete, or misleading information is guilty of a felony.

For Residents of Puerto Rico: Any person who, knowingly and with intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

Notice for Residents of All Other States: 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 may be guilty of a crime and may be subject to fines and confinement in prison.