Please fax the completed form to:
Fax Number: 833-357-5153
The Hartford
P.O.Box 14869
Lexington, KY 40512-4869
Email: GBInformationUpload@thehartford.com

ATTENDING PHYSICIAN'S STATEMENT

THE HARTFORD

To be completed by the Employee

Patient Name:	Date of Birth:	Insured ID Number:

Patient Address: (Street, City, State & Zip Code)

To be completed by the Provider - Use current information from your patient's most recent office visit or examination to complete this form. (The patient is responsible for the completion of this form without expense to the Company.)

Patient's condition is the result of: ☐ Sickness ☐ Injury ☐ Pregnancy

If pregnancy, what is the expected date of delivery? _____ Month _____ Day _____ Year

Is condition due to illness or an injury that is related to: ☐ Work Activity ☐ Motor Vehicle Accident

Medical Conditions Impacting Activity

Primary condition: _____ ICD-9 Code: ☐ _____ ICD-10 Code: ☐ _____

Secondary condition(s): _____ ICD-9 Code: ☐ _____ ICD-10 Code(s): ☐ _____

Subjective symptoms: _____

Objective Physical Findings (Please include office notes for date(s): _____ to _____

Pertinent Test Results (list all results or attach test results):

Test: _____ Date: _____ Results: _____

Test: _____ Date: _____ Results: _____

Condition(s) Specific Medications, Dosage and Frequency:

Treatments

Date your patient reported stopping work: _____ Date of disability: _____ Expected Return to Work Date: _____

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

Date of reported onset of this condition: _____ Date of most recent treatment: _____

How often has patient been seen/treated for this condition? _____ Date of next office visit: _____

Current Treatment Plan: _____

Has surgery been performed? ☐ Yes ☐ No Is surgery planned? ☐ Yes ☐ No If "Yes," Date: _____

Procedure: _____ CPT Code: _____

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

Name of Hospital: _____ Telephone Number of Hospital: (___) _____

Has patient been referred to any other physician? ☐ Yes ☐ No If "Yes," Date(s) of Referral: _____ _____

Other Physician Name: _____ Phone Number: (___) _____ Specialty: _____

Other Physician Name _____ Phone Number: (___) _____ Specialty: _____

Patient Name: Date of Birth: Insured ID Number:

Complete this section to the best of your ability. Generalized comments such as "unable to work" may delay your patient's disability benefits.

Based on your medical findings and opinion, address the full range of restrictions/limitations at the time patient stopped working, reduced their work schedule or initially visited your office for this condition, noting that we will conclude there are no restrictions on function unless specified below.

Restrictions/Limitations based on office visit dated: _____

In an 8 hour period the patient is able to: (select either continuous or intermittent)

	Continuously with standard breaks		Intermittently with standard breaks	If intermittent circle time for each section below	
				Hours at one time	Total hours/8 hours
Sit	☐	or	☐	1 2 3 4 5 6 7 8	1 2 3 4 5 6 7 8
Stand	☐	or	☐	1 2 3 4 5 6 7 8	1 2 3 4 5 6 7 8
Walk	☐	or	☐	1 2 3 4 5 6 7 8	1 2 3 4 5 6 7 8

Provide medical findings/rationale for your opinion if patient is unable to continuously sit, stand or walk:

Activity Ability (with normal breaks)	Never 0 hours	Occasionally up to 2.5 hours	Frequently 2.5 to 5.5 hours	Constantly 5.5 to 8 hours	Please indicate diagnosis, symptoms, exam findings, and/or imaging that supports the restrictions/limitations
Bend at waist	☐	☐	☐	☐	
Kneel/crouch	☐	☐	☐	☐	
Climb	☐	☐	☐	☐	
Balance	☐	☐	☐	☐	
Drive	☐	☐	☐	☐	
Lift - Indicate weight in pounds		____ lbs.	____ lbs.	____ lbs.	
Other Restrictions (if any) _____	☐	☐	☐	☐	
Hand Dominance: ☐ Right ☐ Left					
Upper Extremity Activity (not load bearing) Specify right (R) or left (L) if not bilateral					
Fine manipulation (fingering, keyboard)	☐	☐	☐	☐	
Gross manipulation (grip/grasp, handle)	☐	☐	☐	☐	
Reach (extend arms) above shoulder	☐	☐	☐	☐	
Reach (extend arms) below shoulder at desk or workbench level	☐	☐	☐	☐	

Please attach copies of imaging results/tests

Expected duration of any restriction(s) or limitation(s) listed above: _____

Current Status (Please check one): ☐ Recovered ☐ Improved ☐ Unchanged ☐ Retrogressed

Additional Comments (If Necessary): _____

Does the patient have a psychiatric / cognitive impairment? ☐ Yes ☐ No If "Yes," please describe the extent of the impairment and its etiology: _____

In your opinion is the patient competent to endorse checks and direct the use of the proceeds? ☐ Yes ☐ No

Provider's Name: (please print or type)	EIN Number:	License Number:

Telephone Number: ( )	Fax Number: ( )	Degree:	Specialty:

Street Address (Street, City, State & Zip Code):

Office Contact and Telephone Number:

Provider's Signature: _____ Date signed: _____

United States of America
Railroad Retirement Board

Form Approved
OMB No. 3220-0039

Application for Sickness Benefits

Section A Identifying Information

1. Employee's Name (First, Middle Initial, and Last)	2. Social Security Number ___ – ___ – ____
3. Employee's Street Address, City, State and ZIP Code (Including Apartment Number)	4. Date of Birth Month / Day / Year __ / __ / __ 5. Sex ☐ Male ☐ Female 6. Telephone Number (Include Area Code) ( )

Section B Infirmity and Employment Information

7. Date You Became Sick or Injured _____
8. Date You Last Worked for a Railroad _____
9. Last Railroad Employer (Name of Company) _____
10. Location of Last Railroad Employment (City/State) _____
11. Last Railroad Occupation _____
12. Department _____
13. If you worked for a nonrailroad employer after the date shown in Item 8, complete Items A, B, and C, below. Otherwise, **go to Item 14.**
    A. Last Nonrailroad Employer (Name of Company) _____
    B. Last Occupation After Railroad Work _____
    C. Date Last Worked After Railroad Work _____

Section C Accident and Insurance Information

14. Are you applying for sickness benefits because you were injured at work or have a work-related illness? ☐ Yes ☐ No
15. Have you filed or do you expect to file a lawsuit or claim against any person or company for personal injury?
    ☐ Yes - **Complete Items A-D, below** ☐ No - **Go to Item 16**
    A. Furnish the name and complete address of the person or company.
    Name _____
    Address _____
    City, State, ZIP Code _____
    B. Give the place where the injury occurred. _____
    C. Were you injured in an automobile accident? ☐ Yes ☐ No - **Go to Item 16**
    D. If you were injured in an automobile accident, provide information about all the vehicles, ***other than your own,*** that were involved in the accident that caused your injury. Information about your vehicle and insurance company is not needed. If you need more space attach a separate sheet of paper.

Owner of Car (other vehicle)	**Driver (other vehicle)**
Name	Name
Address	Address
City, State, ZIP Code	City, State, ZIP Code
Insurance Company (other vehicle)	**Policy Information (other vehicle)**
Name	Policy Number
Address	Claim Number
City, State, ZIP Code	

Continued on Reverse Side

Section D Claim for Sickness Benefits Information

16. Enter the earliest date you wish to claim sickness benefits. _____

17. Are you claiming all the days of sickness beginning with the date you entered in Item 16? (**Note:** You may claim rest days if you were unable to work and did not receive pay from your employer.) ❑ Yes - **Go to Item 19** ❑ No - **Go to Item 18**

18. Enter any dates that you do not wish to claim. _____

19. Enter the date you returned to work (if applicable). _____

20. **You must complete all boxes** to indicate if you have received or will receive any of the following payments for your days of sickness. If you check "YES" for any item, be sure to provide the requested information.

A. WAGES (Include Railroad and Nonrailroad Wages)

YES	NO	**If "YES," show the dates for which you were paid in Month/Day/Year format below.**
❑	❑	Regular Wages. . . . .
❑	❑	Vacation Pay . . . . .
❑	❑	Holiday Pay . . . . .
❑	❑	Military Reservist Pay . . . . .
❑	❑	Wage Continuation Pay . . . . .
❑	❑	Earnings from Self-Employment . .
❑	❑	Sick Pay from Your Employer . . . .

(but not payments supplementing Railroad Retirement Board (RRB) benefits. See Booklet UB-11)

B. GOVERNMENTAL PAYMENTS (Not RRB Sickness Benefits)

YES	NO	**If "YES," enclose copy of award letter and complete Items 1 - 3 below.**
❑	❑	Sickness or Unemployment Benefits Under Any Other Law
❑	❑	Social Security Benefits
❑	❑	Railroad Retirement or Disability Annuity
❑	❑	Military Retirement Pay
❑	❑	Worker's Compensation
❑	❑	Retirement Payments Under Another Law

1. Beginning Date of Payment _____
2. Gross Amount of Payment $ _____
3. How often do you receive the payment?
   ❑ Weekly ❑ Monthly ❑ Yearly
   ❑ Other: _____

C. OTHER PAYMENTS

YES	NO	**If "YES," complete Items 1 and 2.**
❑	❑	Settlement, Judgment or Damages for Personal Injury
❑	❑	Advances
❑	❑	Separation Allowance (Buyout, Severance Pay)

1. Date of Payment _____
2. Paid By: _____

21. If the date you are submitting this form is **more than 30 days** after the date you entered in Item 16, answer the following:
A. Why did it take more than 30 days to submit this form? If more space is needed, attach a separate sheet of paper.

_____

B. How did you obtain this form? _____

C. Who provided this form to you? _____

D. On what date did you obtain the form? _____

E. Furnish the name and title of any person from whom you asked for help in completing and filing the forms.

NAME _____ TITLE _____

Section E Direct Deposit Information

22. Benefits are normally paid by Direct Deposit to your bank, savings and loan, credit union, or other financial institution. To provide the information we need to correctly deposit your payments, **attach a voided personal check and go to Item 23**, or call your financial institution for the information you need to complete Items A-E.

A. Routing Transit Number ☐☐☐☐☐☐☐☐☐ B. Account No. _____

C. Account Type:
❑ Checking ❑ Saving

D. Name of Financial Institution: _____

E. Telephone No. (Include Area Code) (_____)_____

Section F Certification and Signature

23. I waive any "doctor-patient privilege" I may have with respect to the disclosure of information concerning the period of sickness or injury on which my claim is based. I certify that I understand and agree to the requirements in Booklet UB-11. I know that disqualification and civil and criminal penalties may be imposed on me for false or fraudulent statements or claims or for withholding information to get benefits from the RRB. I affirm that the information given on this form is true, correct and complete. **NOTE:** If the sick or injured employee is unable to sign this form, sign your name and complete Section 1 of the attached Form SI-10, Statement of Authority to Act for Employee.

SIGNATURE _____ **DATE** _____

United States of America
Railroad Retirement Board

Form approved
OMB No. 3220-0034

Statement Of Authority To Act For Employee

It is not necessary to complete this form for an employee who can sign papers or can sign by mark and understands transactions relating to his or her sickness benefits.

Instructions

1. Complete Section 1 and have the employee's medical doctor complete Section 2. If you are not related to the employee by blood or marriage, state your relationship and explain why no relative is acting for the employee. For example, an employee's union representative might explain: "I am his union chairman. He has no immediate family."

2. Complete this statement by following the instructions in the UB-11 booklet under "Instructions for Completing Forms, Statement of Authority to Act for Employee (SI-10)." Signing this statement gives you the authority to sign any claim forms on behalf of the employee. When signing claim forms use your full name, and beneath your signature, write "On behalf of" and the employee's full name.

3. Return this form with the next application or claim form you file with the RRB.

Section 1 Statement of Individual Acting for Employee

It is my belief that _____ _____
(Employee's Name) (Social Security Number)

whose address is _____
(Employee's Address)

is at this time incapable of signing forms in connection with obtaining sickness benefits under the Railroad Unemployment Insurance Act; of transacting the necessary business relative to his or her application and claims for such benefits; and of applying the proceeds of any sickness benefit payments.

I believe the employee to be incapable because _____

_____
(Briefly describe employee's condition)

My relationship to the employee is _____

I affirm that, in the transaction of business relating to the application and claims of this employee, including the use of any benefit payments, I will act on behalf of and in the best interest of the employee. I will promptly notify the RRB at such time as this employee's condition changes so that I need no longer act for him or her. I understand that criminal and civil penalties may be imposed on me for providing false, incomplete, or fraudulent statements; using the benefits received on something other than the claimant; or for withholding information to cause the payment of benefits. I certify that, to the best of my knowledge, the information I have provided is true, complete, and correct.

Name (please print)	Signature			Phone Number ( )
Street Address (please print)	City	State	ZIP Code	Date

Section 2 Statement of Employee's Doctor

I have examined the employee named above and find that he/she is incapable of signing forms and transacting business relative to his/her claims for sickness benefits under the Railroad Unemployment Insurance Act.

Name of Doctor (please print)	Signature of Doctor			
Office Street Address (please print)	City	State	ZIP Code	Date
National Provider Identifier				

United States of America
Railroad Retirement Board

Form Approved
OMB No. 3220-0039

Statement of Sickness

Instructions: ***This form is to be executed by (1) a doctor trained in medical, surgical, dental or psychological diagnosis of the infirmity described, (2) a certified nurse/midwife in cases of pregnancy or childbirth, (3) a supervisory official of a hospital or similar institution, (4) a chiropractor, (5) a Physician Assistant - Certified, or (6) a nurse practitioner. This form should be completed and returned to the patient immediately for prompt mailing; otherwise he/she may lose benefits. Supplementary medical information may be attached or furnished directly to the Railroad Retirement Board (RRB) at the address shown below. If such information is furnished, please include the patient's social security number and name on the report. Please complete section 2 on the reverse side if patient is incapable of signing forms.***

The RRB is not liable for any charge in connection with completing this form.

1. Patient's Name (First, Middle, and Last)

2. Patient's Social Security Number

3. Have you examined or treated the patient for his or her injury or illness? ☐ Yes ☐ No – **Go to Item 9**

a. Date patient became sick or injured

b. List all dates of examination and treatment for this infirmity

c. Probable date of next examination

4. Diagnosis and concurrent conditions

5. Does the patient's condition require surgery? ☐ Yes ☐ No – **Go to Item 6**

a. Date on which surgery was or will be performed

b. Surgical procedure that was or will be performed

6. Does the patient's condition require hospitalization?

☐ Yes – Enter the period of hospital confinement: From _____ To _____

☐ No

7. If patient is not working because of maternity or childbirth, complete 7a and 7b.

a. Date patient became unable to work ▶

b. Estimated or actual date of delivery ▶

8. Give the date you believe the patient became or will become able to resume work in his or her occupation. (If indefinite or unknown, please give an estimated date.) ▶

9. I certify that the information I am giving is true, complete, and correct. I understand that criminal and civil penalties may be imposed on me for false or fraudulent statements or for withholding information to cause or prevent payment of benefits by the RRB.

Please print or type:

Name of Doctor	Signature of Doctor	Degree/Title
Address	Office Telephone Number (Include Area Code) ( )	Date
	National Provider Identifier	

PAPERWORK REDUCTION ACT NOTICE TO DOCTOR

Medical evidence is needed to support the payment of claims for sickness benefits under the Railroad Unemployment Insurance Act (RUIA). The RRB is authorized to collect this information under section 12(i) of the RUIA. You are not required to furnish this information. If you do not, however, no benefits can be paid to your patient. We estimate this form and the form on the back of this page take an average of 8 and 6 minutes to complete, respectively. The estimates include the time for reviewing the instructions, getting the needed data, and reviewing the completed forms. Federal agencies may not conduct or sponsor, and respondents are not required to respond to, a collection of information unless it displays a valid OMB number. If you wish, send comments regarding the accuracy of our estimate or any other aspect of this form, including suggestions for reducing completion time, to the Chief of Information Resources Management, Railroad Retirement Board, 844 N Rush Street, Chicago, Illinois, 60611-2092. Send completed forms to:

U.S. RAILROAD RETIREMENT BOARD
OFFICE OF PROGRAMS—OPERATIONS
POST OFFICE BOX 10695
CHICAGO, ILLINOIS 60610-0695