Underwriting Company *:

☐ CNA Group Life Assurance Company
☐ Continental Casualty Company

For Assistance Call: 1-800-303-9744

PHYSICIAN'S STATEMENT

PLEASE PRINT – Use a separate sheet of paper to answer questions where space does not permit. Section A is to be completed by the Employee. Section B is to be completed by the Attending Physician.

A.

Patient's Name	Date of Birth
Patient's Address – Street, City, State, Zip Code	Phone Number (Area Code First)
Employer's Name **Louisiana State University System**	Policy Number **83116904**

I hereby authorize release of information on this form , by the physician name on the second page or reverse side of this form

For the purpose of claim processing. Signature: ____ Date: _______________

B.

1. HISTORY

(a) When did symptoms first appear or accident happen? Month ___________ Day _______ Year________

(b) Date of first visit: Month ___________ Day _______ Year________

(c) Date you first advised patient to cease work: Month ___________ Day _______ Year________

(d) Has patient ever had same or similar condition? ☐Yes ☐No
If yes, please state when and describe:

(e) Is condition due to injury or sickness arising out of patient's employment? ☐Yes ☐No ☐Unknown

2. MEDICAL CONDITION

(a) Diagnosis:

(b) Complications:

(c) Symptoms:

(d) OBJECTIVE FINDINGS (Please attach reports including x-rays, EKG's, Lab Data and any clinical findings):

3. NATURE OF TREATMENT

(a) What are the treatment plans?

(b) Surgery:

(c) Medications:

(d) Has this person been referred to another physician? ☐Yes ☐No
Name and address of this physician:

(e) Date of last visit: Month ___________ Day _______ Year________

(f) Is further treatment required?

4. PHYSICAL LIMITATIONS

What are the specific limitations (i.e., lifting, standing, stooping)

5. Does this person have mental or nervous limitations? ☐ **Yes** ☐ **No**

If yes, please describe:

5. PROGNOSIS (Recovery and return to work date)

REMARKS:

Name (Physician) Please Print	Specialty	Telephone ( )
Address – Street, City or Town, State or Province, Zip Code		
Signature (**Physician's original signature is required**)		Date

* Unless indicated otherwise above, the underwriting company will be CNA Group Life Assurance Company. If CNA Group Life Assurance Company is not authorized to issue coverage in connection with the above policy, then coverage will be provided by Continental Casualty Company.

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