ATTENDING PHYSICIAN'S STATEMENT

This form is to be completed without expense to Lincoln Financial and returned along with your original claim for benefitsor by the date requested by the Lincoln Financial Claims Dept.

Group Market Disability Claims Liberty Life Assurance Company of Boston,
A Lincoln Financial Group Company
P.O. Box 7211
London, KY 40742-7211
Phone No.: 888-440-6118
Fax No.: 603-422-0117

Return to: _____

PART A: TO BE COMPLETED BY EMPLOYEE

EMPLOYEE/CLAIMANT NAME: _____

CLAIM NO.: _____ S.S. NO.: _____ - _____ - _____

EMPLOYER/SPONSOR: _____ DATE OF BIRTH: _____

AUTHORIZATION TO OBTAIN AND RELEASE INFORMATION

I authorize any licensed physician, medical provider, hospital, medical facility, HMO, pharmacy, government agency, including the Social Security Administration and Veterans Administration, insurance or reinsurance company, credit or consumer reporting agency, financial/educational institutions and any current or former employer to release any and all medical information with respect to my physical or mental condition and/or treatment of me, including confi dential information regarding AIDS/HIV infection, communicable diseases, alcohol and substance abuse, mental health and any non-medical information to the particular Company in the Lincoln Financial Group of companies to which I am submitting a claim, or to its legal representative, or to the Plan Sponsor (if Self Insured Plan), or to persons or other organizations providing claims management services.

I understand the Company or Plan Sponsor will use the information obtained under this Authorization or directly from me to determine eligibility for insurance benefi ts, which may include assessing ongoing treatment. Any information obtained will not be released to any person or organizations EXCEPT to the Plan Sponsor, reinsuring companies, other companies in the Lincoln Financial Group of companies to which I am submitting a claim, Employee Assistance Programs (EAP) or other disease management or assistance programs providing services to the Plan Sponsor and/or to the Company, persons or other organizations providing claims management and claim advisory services to the Plan Sponsor and/or to the Company, the Group Policyholder or its agents/vendors for purposes of auditing the Company's administration of claims under the policy and/or assessing statistical claim data related to its benefi t programs, and persons or organizations providing medical treatment or services in connection with my claim, or as may be otherwise permitted or required by law.

If I receive a disability benefi t greater than that which I should have been paid, I understand that the Company has the right to recover such overpayment from me, including the right to reduce future disability benefi ts, if any.

I understand that any person who knowingly, and with intent to injure, defraud, or deceive the Company and/or Plan Sponsor, fi les a statement or claim containing any false, incomplete, or misleading information may be guilty of a criminal act punishable under law.

I know that I may request a copy of this Authorization. I agree that a photographic copy of this Authorization shall be as valid as the original. This Authorization shall become effective on the date appearing next to my signature below. I understand that this Authorization shall be valid for two years from the date appearing below with my signature and that I have the right to revoke this Authorization at any time by written notifi cation to the Company in the Lincoln Financial group of companies to which I submit a claim and/or the Plan Sponsor.

Date | Claimant's Signature (or Authorized Representative)

PART B: TO BE COMPLETED BY ATTENDING PHYSICIAN

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 DETERMINATION OF YOUR PATIENT'S DISABILITY BENEFITS.

THE CLINICAL INFORMATION, IN COMBINATION WITH THE PHYSICAL FACTORS OF YOUR PATIENT'S JOB AND THE CONTRACTUAL PROVISIONS UNDER WHICH HE/SHE IS COVERED, WILL BE USED TO ESTABLISH THE MOST APPROPRIATE WORK ABSENCE DURATION.

1. DIAGNOSIS

Primary _____ ICD9 _____
Secondary _____ ICD9 _____
_____ ICD9 _____

Has patient ever had the same or a similar condition? Yes _____ No _____
If "Yes", state when and describe.

What is your prognosis?

For Pregnancy:
EDC _____ Date of Delivery _____ Type _____

2. DATES OF TREATMENT

(a) Date of First Visit _____ (mo/day/yr)
(b) Date of Last Visit _____ (mo/day/yr)
(c) Frequency of Visits ____ Weekly ____ Monthly ____ Other (specify)
(d) Date of First Treatment _____ (mo/day/yr)
(e) Date Symptoms First Appeared / Accident Occurred _____ (mo/day/yr)
(f) Date Patient Advised to Cease Work _____
(g) Estimated Return to Work Date _____

PHYSICIAN, PLEASE COMPLETE THE REVERSE SIDE OF THIS FORM.

PART B, cont.: TO BE COMPLETED BY ATTENDING PHYSICIAN

3. Please describe in detail your PROPOSED TREATMENT PLAN. Please list all medications the patient is taking for this condition. Include your prognosis as a result of this treatment plan. IDENTIFY ANY RESTRICTIONS you have imposed on your patient at this time.

4. PHYSICAL IMPAIRMENT

____ Class 1 - No limitation of functional capacity; capable of heavy work.
____ Class 2 - Medium manual activity.
____ Class 3 - Slight limitation of functional capacity; capable of light work.
____ Class 4 - Moderate limitation of functional capacity; capable of clerical/administrative activity.
____ Class 5 - Severe limitation of functional capacity; incapable of minimum activity.

REMARKS:

5. MENTAL/NERVOUS IMPAIRMENT

____ Class 1 - Patient is able to function under stress and engage in interpersonal relations (no limitations).
____ Class 2 - Patient is able to function in most stressful situations and engage in most interpersonal relations (slight limitations).
____ Class 3 - Patient is able to engage in only limited stressful situations and engage only in limited interpersonal relations (moderate limitations).
____ Class 4 - Patient is unable to engage in stressful situations or engage in interpersonal relations (marked limitations).
____ Class 5 - Patient has significant loss of psychological, physiological, personal, and social adjustment (severe limitations).

REMARKS:

6. CARDIAC IMPAIRMENT (if applicable)

Functional Capacity: ____ Class 1: No Limitation ____ Class 2: Slight Limitation
(per American Heart Assn) ____ Class 3: Marked Limitation ____ Class 4: Complete Limitation
Blood Pressure (last visit): _____ (systolic/diastolic)

7. Date of Next Scheduled Visit

Are you still treating the patient? ____ Yes ____ No
If patient has been referred to another physician, please indicate the name of physician, address, telephone number, and reason for referral.

Was patient referred to you by another physician? ____ Yes ____ No

8. Has patient been hospital confined? ____ Yes ____ No
Dates of Confinement: From _____ to _____
Was surgery performed? ____ Yes ____ No If "Yes", please indicate procedure(s) performed:
CPT Code: _____ Date Performed _____
Name and Address of Hospital:

9. After you have completed this form, please attach copies of the following materials:
Office notes for the period of treatment or for the last two years
Test Results showing medical evidence
Hospital discharge summary (if applicable)
Consulting physician's reports (if applicable)

10. REMARKS

Attending Physician's Name (PLEASE PRINT)	Degree/Specialty	SS No. or Tax ID No.
Street Address	( ) Telephone No.	( ) Fax No.
City/State/Zip Code	Signature	Date