AMERICAN FIDELITY
a different opinion

Worksite Group Benefits Department | P.O. Box 25160 | Oklahoma City, Oklahoma 73125-0160
American Fidelity Assurance Company | 1-800-662-1113 | Fax: 1-800-818-3453 | **americanfidelity.com**

Attending Physicians Statement Waiver of Premium Form to be completed by physician

Name of Patient:	Social Security Number: / /	Account Number:
Date of Birth: / /		ICDA Code:

Diagnosis (including complications):	
Subjective Symptoms:	
Objective Findings: (Give report of x-rays, E.K.G.s, or any other special tests)	
Is Insured: ❒ Ambulatory ❒ Bed Confined ❒ House Confined ❒ Hospital Confined	
Frequency of treatment: ❒ Monthly ❒ Weekly ❒ Other, describe If not under your regular care and attendance please explain.	
Nature of treatment being rendered (including surgery and any medications being prescribed) and the current treatment plan:	
Has the patient been confined to a hospital: ❒ Yes ❒ No	Admitted: / / Discharged: / /
If yes, give admit and discharge dates along with name and address of hospital. Name: Address:	Admitted: / / Discharged: / /
Dates of total disability: (unable to work) From: / /	Through: / /
Disabled from: Patient's Job ❒ Yes ❒ No	Any other work ❒ Yes ❒ No
What duties of patient's job is he/she incapable of performing?	
If the patient if currently disabled what is the anticipated length of disability: ❒ 1-2 Months ❒ 2-3 Months ❒ 3-6 Months ❒ 6-12 Months ❒ More than 12 Months ❒ Permanent	
When, in your opinion will the patient recover sufficiently to return to work?	

PHYSICIAN INFORMATION

Attending Physician's Name & Title: (print)	Specialty:
Phone:	Fax:
Mailing Address: (P.O. Box or Street, City, State and Zip Code)	
Form Completed By: (Name & Title)	Signature: Date: / /