

Waiver of Premium Form To be completed by your physician.

Name of Patient:	Social Security Number:	Account Number:
Date of Birth: (MM/DD/YYYY)	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 If yes, give admit and discharge dates, along with the name and address of the hospital.		
Hospital Name: Admitted: (MM/DD/YYYY)		Address: Discharged: (MM/DD/YYYY)
Hospital Name: Admitted: (MM/DD/YYYY)		Address: Discharged: (MM/DD/YYYY)
Dates of total disability: (unable to work) From: (MM/DD/YYYY) Through: (MM/DD/YYYY)		
Disabled from: Patient's Job ☐ Yes ☐ No Any other work ☐ Yes ☐ No		
What duties of patient's job are they 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 Number: (with area code)	Fax: (with area code)
Mailing Address: (P.O. Box or street, city, state, zip)	Form Completed By: (Name & Title)
Signature:	Date: (MM/DD/YYYY)