

Administrative Office
P.O. Box 64340
St Paul, MN 55164-0340

Phone: 1-844-975-7522
Fax: 1-877-888-2677
Email: MassMutualService@illumifin.com
Online: www.MassMutual.com/retirement/worksite-benefits

B To Be Completed By Physician *continued* ::::::::::::::::::::::::::::::::::

- 12. Please check the degree of work that the patient is able to perform:
 - Heavy Work: Lifting 100 lbs. maximum with frequent lifting and/or carrying of objects weighing 50 lbs. or more.
 - Medium Work: Lifting 50 lbs maximum with frequent lifting and/or carrying of objects weighing up to 25 lbs.
 - Light Work: Lifting 20 lbs. maximum with frequent lifting and/or carrying of objects weighing up to 10 lbs. Even though the weight lifted may be only a negligible amount, a job is in this category when it involves sitting most of the time with a degree of pushing and pulling of arm and/or leg controls, or when it requires walking or standing to a significant degree.
 - Sedentary Work: Lifting 10 lbs. maximum and occasionally lifting or carrying such articles as docket, ledgers, and small tools. Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are sedentary if walking and standing are required only occasionally and other sedentary criteria are met.
 - Less than Sedentary work
- 13. On what date did you advise your patient to limit or stop working? (mm/dd/yyyy): _____
- 14. Do the current symptoms result in occupational restrictions (**things your patient should not do**)? If so, please describe.

- 15. Do the current symptoms result in occupational limitations (**things your patient is unable to do**)? If so, please describe.

- 16. Anticipated length of time for restrictions and limitations? _____
- 17. Is return to work planning incorporated into the treatment plan? Yes No
If yes, when is return to work expected? _____ full-time part-time
(Month, Day, Year)
- 18. Does this patient have the capacity to manage his/her property unassisted, and to understand the nature and consequence of his/her actions, including the ability to endorse checks and direct the use of the proceeds? Yes No
If no, to your knowledge, has a formal competency hearing been completed? Yes No
Date of competency hearing _____
(Month, Day, Year)
- 19. Additional remarks regarding patient's condition(s): _____

C Physician's Signature ::::::::::::::::::::::::::::::::::

Please be sure to attach office notes, test results and discharge summaries.

Fraud Notice
Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. This includes Claimant and Physician portions of the claim form.
The above statements are true and complete to the best of my knowledge and belief.

Physician's Name (Please print): _____

Physician's Degree: _____ Physician's Specialty: _____

License Number: _____


Address: _____
Street City State Zip Code

Telephone Number: _____ Fax Number: _____

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Email Address: _____

 Physician's Signature: _____ Date:

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A Personal Information ::

1. Policy/Certificate number(s): _____
2. Insured full legal name (*First, MI, Last, Suffix*): _____
3. Address (Street, City, State, Zip Code): _____

4. Insured date of birth (*mm/dd/yyyy*): _____
5. Telephone (Day): _____
6. Telephone (Evening): _____

B Insured's Employment Information ::

Employer:	Address and Telephone:
Were you employed when injured or sickness began? <input type="checkbox"/> Yes <input type="checkbox"/> No	Occupation and nature of duties:
Are you filing for Worker's Compensation? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you filing for, or currently receiving, Social Security Benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No If you are currently receiving benefits, what date did payment begin?

C Insured's Disability Information ::

Describe the cause of your disability:	
Date when your health first began to be affected:	Date you became totally disabled so as to be prevented from doing any work:
Are you now totally disabled and unable to work? <input type="checkbox"/> Yes, Date you expect to return to work: _____ <input type="checkbox"/> No, Date you returned to work: _____	Describe briefly, your present daily activities (such as cooking, cleaning, shopping, watching TV):

D Physician Information ::

Name, address and telephone of physician consulted for your present disability (include name of clinic or hospital):	Dates Consulted:
Names, addresses and telephone of all other physicians consulted in the last 2 years :	Disease or Condition:
	Dates:

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Names, addresses and telephone of all hospitals or institutions where you have been confined in the last 2 years :	Dates:	Disease or Condition:
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E Authorization ::

I authorize any hospital, physician or other person who has attended me, my employer, or other informant, to furnish and disclose any information acquired to MassMutual, upon presentation of this authorization or photocopy of this authorization. This authorization shall remain valid as long as this certificate remains in force.

I certify that this Claimant Statement is complete and accurate to the best of my knowledge.

All states except New York – Read the applicable fraud language for your state in the Fraud Warning section.

New York only - Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

 Signature of Insured: _____

Printed Name: _____ Date:

m	m	/	d	d	/	y	y	y	y
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F Fraud Warnings ::

CA: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

CO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

DE, ID & OK: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

FL: Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

GA, MT, OR: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

MA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

MD, MN: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

ME: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

NJ: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NM: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

OH: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

PA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

TN: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.



Waiver of Premium/Monthly Charges Proof Disability Form

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VA: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated Virginia law.

VT: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

WA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Applicants of All Other States: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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B Agreement and Signatures ::

Signature of Claimant: _____ Date (mm/dd/yyyy): _____

If Power of Attorney designee, Guardian or Conservator, attach a copy of the document granting authority and sign below.

I, _____ (name) signed on behalf of the Insured as _____ (relationship).