I hereby authorize any physician, hospital, pharmacy, insurance company, employer, or organization to release any information regarding medical history, treatment, or impairment to SEBT, for the purpose of validating and determining coverage available in connection with this application. Data without personal identification may be extracted for use in statistical studies.

Signature of Employee: _____ Date: _____

Attending Physician's Statement of Impairment

Name of Patient:		Address:	
City:	State:	Zip Code:	Date of Birth:
Name of Parent/Subscriber:		Group #	Employer:

History

• When did symptoms first appear or accident happen?	Month:	Day:	Year:
• Date patient ceased work because of disability. (if applicable)	Month:	Day:	Year:
• Had patient ever had same or similar condition? If yes, state when and describe. _____ Yes _____ No	Date:	Description:	

Present Condition

• Did this incapacity exist prior to the dependent's 26th birthday? _____ Yes _____ No			
• Subjective symptoms:	Describe:		
• Objective symptoms: (include results of EKG's, current X-rays, or any other special tests)	Describe:		
• Is the patient: ___ Ambulatory _____ Bed Confined _____ House Confined _____ Hospitalized			

Diagnosis Including Prognosis

Treatment

• Frequency of visits:	Weekly:	Monthly:	Other:
• When did you last examine this patient:	Month:	Day:	Year:
• Degree of psychiatric impairment:	_____ None	_____ Mild	_____ Severe
• Degree of physical impairment:	_____ None	_____ Mild	_____ Severe
• Is this patient capable of holding self-sustaining employment at this time? If yes, please comment: Yes or No	Comment:		

Name of Hospital(s)

• Please name hospital(s), if ever admitted as an in-patient:	Admission Date(s):	Discharge Date(s):

Progress

_____ Recovered _____ Improved _____ Unimproved _____ Retrogressed

To the best of this physician's knowledge, is the patient's impairment permanent or is there a chance for enough recovery that patient could become independent from subscriber and; therefore, not meet the requirements for insurance coverage through NBHP?

• PERMENANT ☐	• TEMPORARY ☐

Attending Physician's Information & Signature

Attending Physician's Printed Name:	Degree:
Social Security or Tax I.D. Number:	Date:
Street Address:	

City or Town:	State:	Zip Code:

_____ _____

Attending Physician's Signature Date of Signature