### Waiver of Premium – Plan 104GP

#### Attending Physician’s Statement

**NOTE:** Great-West assumes no responsibility for any expense incurred in the completion of this statement.

<table>
<thead>
<tr>
<th>Name of patient</th>
<th>Date of birth</th>
<th>Month / Day / Year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient’s address</th>
<th>Number</th>
<th>Street</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

I hereby authorize release of information requested on this form, by the below named physician for the purpose of claim processing. I understand any information obtained will not be released by Great-West Life & Annuity Insurance Company to any person or organization EXCEPT to reinsuring companies, or the persons or organizations performing business or legal services in connection with my claim.

Signed (Patient) ▶

Date / /

#### 1. History

(a) When did symptoms first appear or accident happen? 
(b) Date patient ceased work because of disability.
(c) Has patient ever had same or similar condition? □ Yes □ No
(d) Is condition due to injury or sickness arising out of patient’s employment? □ Yes □ No □ Unknown
(e) If condition due to automobile accident, indicate state in which it occurred
(f) Names and addresses of other treating physicians

#### 2. Diagnosis (including any complications)

(a) Date of last examination.
(b) Diagnosis (including any complications)
(c) If disability due to pregnancy what is expected/was delivery date.
(d) Please describe any complications that would extend this disability longer than for a normal pregnancy.
(e) Subjective symptoms
(f) Objective findings (including current X-rays, EKG’s, Laboratory Data and any clinical findings)

#### 3. Dates of Treatment

(a) Date of first visit.
(b) Date of last visit.
(c) Frequency □ Weekly □ Monthly □ Other (specify)

#### 4. Nature of Treatment (including surgery and medications prescribed, if any)

#### 5. Progress

(a) Has patient □ Recovered? □ Improved? □ Remained unchanged? □ Retrogressed?
(b) Is patient □ Ambulatory? □ House confined? □ Bed confined? □ Hospital confined?
(c) Has patient been hospital confined □ Yes □ No □ Unknown

Date of Admission: Mo. _____ Day _____ 20 _______ Date of Discharge: Mo. _____ Day_____ 20 _______

Form M3658 (Rev.09/12)
6. **Cardiac (if applicable)**
   (a) Functional capacity………………………
       - Class 1 (No limitation)
       - Class 2 (Sight limitation)
       - Class 3 (Marked limitation)
       - Class 4 (Complete limitation)
       (American Heart Association)
   (b) Blood pressure (last visit)………………
       - Systolic ____________________
       - Diastolic ____________________

7. **Physical Impairment (*as defined in US Dept of Labor Dictionary of Occupations Titles) Please offer your recommendations**
   - Class 1 - No limitation of functional capacity; capable of heavy work*…………………………………………………………..No restrictions (0-10%)
   - Class 2 - Medium manual activity*………………………………………………………………………………………………………………(15-30%)
   - Class 3 - Slight limitation of functional capacity; capable of light work*……………………………………………………………………..(35-55%)
   - Class 4 - Moderate limitation of functional capacity; capable of clerical/administrative (sedentary*) activity…………………………(60-70%)
   - Class 5 - Severe limitation of functional capacity; incapable of minimal (Sedentary*) activity………………………………………………..(75-100%)

8. **Mental/Nervous Impairment (if applicable)**
   What stress and problems in interpersonal relations has claimant had on job?
   - 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 stress situations and engage in most interpersonal relations (slight limitations)
   - Class 3 - Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations (moderate limitations)
   - Class 4 - Patient is unable to engage in stress situations or engage in interpersonal relations (marked limitations)
   - Class 5 - Patient has significant loss of psychological, physiological, personal and social adjustment (severe limitations)

9. **Do you believe the patient is competent to handle personal business matters?**
   - Yes  □  No □

10. **Prognosis**
    (a) Has patient made significant progress?  □ Yes □ No
        Please explain:
    (b) What changes do you expect in the near future?

11. **Rehabilitation and return to work.**
    (a) As of what date do you recommend patient to return to own occupation?
        □ Part-time ______/_______/_______  □ Full-time ______/_______/_______
    (b) As of what date do you recommend patient to return to any other work?
        □ Part-time ______/_______/_______  □ Full-time ______/_______/_______
    (c) Is patient a suitable candidate for occupational rehabilitation?  □ Yes □ No

12. **Remarks**

---

**Name (attending physician) / Please Print**

**Degree / Specialty**

**Telephone**

**Street Address**

**Fax**

**City or Town**

**State**

**Zip Code**

**Signature **

**Date**

*Stamp or signature other than physician's own signature will not be accepted.*