TSPI MUTUAL BENEFIT ASSOCIATION INC.

MICRO INSURANCE

(annex form no. 1)

INSURED'S AUTHORIZATION

I HEREBY AUTHORIZE any physician or other person or any hospital, sani ı to furnish the MUTUAL BENEFIT ASSOCIATION, INC., any information that may be required concerning my illness or disability.

This authorization discharges you or any authorized member of your staff from any responsibility or obligation in connection with the release of such record and information.

Signed at _____ this _____ day of _____, 20 _____.

_____ WITNESS

_____ INSURED

ATTENDING PHYSICIAN'S STATEMENT OF DISABILITY

INSTRUCTION: This form shall be accomplished by each and every physician on the injury/sickness sustained. Please answer fully all questions.

(A) Patient's Name in Full:	(B) Date of Birth
	(C) Occupation
(D) ADDRESS: No. Street City or Town Province Area Code	
(E) ARE YOU HIS REGULAR PHYSICIAN?	(F) HOW LONG HAVE YOU KNOWN HIM?

2. (A) DATE OF YOUR FIRST TREATMENT FOR THE INJURY/SICKNESS SUSTAINED.
_____
(B) DATE OF MOST RECENT EXAMINATION _____
(C) WHEN WAS THE INJURY/SICKNESS SUSTAINED_____
(D) WAS THE INJURY/SICKNESS SUSTAINED IN ACCIDENT?_____
(E) WAS THE INJURY/SICKNESS RELATED TO OR A RESULT OF HIS OCCUPATION?
_____
_____
_____

PLEASE STATE DETAILS: (Use reverse side if necessary)

(F) HAS HE BEEN TREATED BY ANY OTHER PHYSICIAN/S? _____
IF SO,

Name Of Physician	Address
_____	_____
_____	_____
_____	_____

3. (A) DIAGNOSIS:

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PRIMARY DISABLING CONDITION: _____
SECONDARY CONDITION: _____
WHAT RESTRICTIONS HAVE YOU PLACED ON PATIENT'S ACTIVITIES?

OBJECTIVE FINDINGS: (CXR, ECG, LAB DATA, ETC) _____

(B) PROGNOSIS:
HAS PATIENT'S CONDITION STABILIZED? _____
HAS PATIENT REACHED MAXIMUM MEDICAL IMPROVEMENT? _____
IS PATIENT A CANDIDATE FOR REHABILITATION? _____
ADDITIONAL COMMENTS: _____

(C) PHYSICAL &/OR MENTAL IMPAIRMENT
_____ NO LIMITATION; MAY RETURN TO WORK
_____ SLIGHT LIMITATION; CAPABLE OF LIGHT WORK
_____ MODERATE LIMITATION: CAPABLE OF SEDENTARY WORK
_____ CANNOT PERFORM PRESENT WORK BUT CAPABLE OF PERFORMING ANOTHER LINE OF WORK
_____ TEMPORARY LIMITATION OF FUNCTIONAL CAPACITY; PERMANENTLY INCAPABLE OF ANY KIND OF WORK
_____ SEVERE LIMITATION OF FUNCTIONAL CAPACITY; PERMANENTLY INCAPABLE OF ANY KIND OF WORK

IF LIMITATION IS TEMPORARY, WHEN SHOULD PATIENT BE ABLE TO RETURN TO WORK?
FULL TIME _____
PART TIME _____

I _____, hereby certify that the answers given above are full, complete, and true. I am a graduate of _____ (Medical School), in year _____ specializing in _____

_____
WITNESS' SIGNATURE

_____
PHYSICIAN'S SIGNATURE

_____
ADDRESS

_____
ADDRESS

_____ _____
PTR NO ISSUE DATE

_____
PLACE ISSUED