

STRESS & MENTAL CAPACITY STATEMENT

Associated Mutual Insurance

3809 Lake Eastbrook Blvd SE, Grand Rapids, MI 49546 • options@associatedmutual.org

Date:	Date of Disability:
Re:	Date of Birth:
Doctor Name:	
AMHI provides Disability coverage for the above individual. To properly evaluate the claim, we are in need of further information.	
1) Current diagnosis (Include 5 Axis)	
2) What treatment is utilized: _____ _____	
A. Give frequency or dates: _____	
B. If medications are used, give dosages and blood levels if performed: _____ _____	
Has your patient been hospitalized? Dates and address: _____ _____	
C. Please provide a concise summary of treatment plan, past response, and objectives of past AND planned treatment: _____ _____	
D. Have psychological tests been performed (i.e. MMPI)? If so, provide copies of test results and indicate whether further testing is planned. _____ _____	
3) Please describe the clinical or progression before and after the initiation of treatment: _____ _____	
4) What activities of daily living is the patient capable or not capable of? (Examples include self care, tasks around the home, social contacts and activities, projects and hobbies, work-like activities reflecting persistence and pace. Please cite specific examples). _____ _____ _____	
5) What specific mental functions related to the patient's usual job or work are affected? _____	
6) What are the specific indicators of this? _____	

7) To what extent are these specific to the particular place of former work, and to what extent to the work in general, independent of location? (For example, please consider the individual's ability to interact with coworkers and supervisors, to understand)

8) Do you feel our insured is currently totally disabled from performing his/her occupation as a _____ Yes No

9) Could your patient perform this same occupation at a different site? Yes No
If not, why? _____

10) Have you discussed possible alternative employment with your patient? Yes No
If yes, please describe the details: _____

11) What are the anticipated restrictions for work outside his/her own occupation? _____

12) When could work duties begin? _____

13) What type of rehabilitation will be needed to facilitate a return to work? _____

14) Please add any additional comments you feel would be beneficial to our understanding of your patient's potential for returning to the work force. _____

15) If our insured is no longer totally disabled, date released to return to work: _____

_____ Signature _____ Date

_____ Specialty _____ Phone

To assist our evaluation we are also requesting copies of your office notes from, _____, to the present.
Any test results or lab studies should be included. A signed authorization for release is attached.