

ATTENDING PHYSICIAN'S STATEMENT OF DISABILITY

GOLDEN STATE MUTUAL LIFE INSURANCE COMPANY • HOME OFFICE • LOS ANGELES, CALIFORNIA 90054

(Waiver of Premium Benefits under Ordinary Life Policies)

The Insured is responsible for the completion of this form without expense to the Company

Space is available on the reverse if you wish to amplify your answers.

You may mail this form direct to:
Golden State Mutual Life Insurance Company
Claims Division
P. O. Box 2332 - Terminal Annex
Los Angeles, California 90054

NAME OF INSURED	POLICY NO.
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PRESENT ADDRESS	<i>No. & Street</i>	<i>City</i>	<i>Zone</i>	<i>State</i>
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1. HISTORY (a) When did present illness begin, or injury occur? (b) Date Insured was obliged to cease work. (c) Is there a previous history of this illness?	_____ _____ _____									
2. PRESENT CONDITION (a) Subjective symptoms (b) Objective findings <i>Give report of x-rays, E. K. Gs., or any other special tests.</i> (c) Is Insured <table style="margin-left: 100px; border: none;"> <tr><td>Ambulatory?</td><td><input type="checkbox"/></td></tr> <tr><td>Bed confined?</td><td><input type="checkbox"/></td></tr> <tr><td>House confined?</td><td><input type="checkbox"/></td></tr> <tr><td>Hospital confined?</td><td><input type="checkbox"/></td></tr> </table>	Ambulatory?	<input type="checkbox"/>	Bed confined?	<input type="checkbox"/>	House confined?	<input type="checkbox"/>	Hospital confined?	<input type="checkbox"/>	_____ _____ _____ _____	
Ambulatory?	<input type="checkbox"/>									
Bed confined?	<input type="checkbox"/>									
House confined?	<input type="checkbox"/>									
Hospital confined?	<input type="checkbox"/>									
3. DIAGNOSIS	_____ _____									
4. TREATMENT (a) Date of first visit Date of last visit Frequency of visits (b) When did you last examine the Insured?	_____ _____ _____ _____									
5. PROGRESS <table style="margin-left: 100px; border: none;"> <tr><td>Recovered</td><td><input type="checkbox"/></td></tr> <tr><td>Improved</td><td><input type="checkbox"/></td></tr> <tr><td>Unimproved</td><td><input type="checkbox"/></td></tr> <tr><td>Retrogressed</td><td><input type="checkbox"/></td></tr> </table>	Recovered	<input type="checkbox"/>	Improved	<input type="checkbox"/>	Unimproved	<input type="checkbox"/>	Retrogressed	<input type="checkbox"/>	_____ _____	
Recovered	<input type="checkbox"/>									
Improved	<input type="checkbox"/>									
Unimproved	<input type="checkbox"/>									
Retrogressed	<input type="checkbox"/>									
6. DURATION OF TOTAL DISABILITY (a) Is Insured still totally disabled and unable to do any work? (b) If still totally disabled, when do you think the Insured will be able to resume any work? <table style="margin-left: 100px; border: none;"> <tr><td>Approximate date</td><td>_____</td><td>YR. _____</td></tr> <tr><td>Indefinite</td><td></td><td></td></tr> <tr><td>Never</td><td></td><td></td></tr> </table> (c) If no longer totally disabled, when was the Insured able to resume any work?	Approximate date	_____	YR. _____	Indefinite			Never			<input type="checkbox"/> YES <input type="checkbox"/> NO MO. _____ YR. _____ _____ MO. _____ DAY _____ YR. _____
Approximate date	_____	YR. _____								
Indefinite										
Never										
7. MENTAL CONDITION (a) Does disability involve a mental condition? (b) If "YES", is the Insured competent to endorse checks and direct use of proceeds thereof?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO									

8. Complete appropriate section, IF disability is due to CARDIAC CONDITION, PULMONARY TUBERCULOSIS, or VISUAL IMPAIRMENT.

H E A R T	(a) CARDIAC (1) Functional capacity (AMERICAN HEART ASS'N.) Class 1 (No limitation) <input type="checkbox"/> Class 2 (Slight limitation) <input type="checkbox"/> Class 3 (Marked limitation) <input type="checkbox"/> Class 4 (Complete limitation) <input type="checkbox"/> (2) Blood pressure:	
T U B E R C U L O S I S	(b) PULMONARY TUBERCULOSIS (1) Extent: Minimal <input type="checkbox"/> Moderately advanced <input type="checkbox"/> Far advanced <input type="checkbox"/> (2) Clinical: (NATIONAL TBC. ASS'N.) Active <input type="checkbox"/> Arrested <input type="checkbox"/> Inactive <input type="checkbox"/> (3) Exercise status: Not ambulatory <input type="checkbox"/> Partially ambulatory <input type="checkbox"/> Living under ordinary conditions of life <input type="checkbox"/> (4) Any adverse laboratory findings? _____ Date Sputum last positive _____ (5) Therapy: _____ Type & Dates _____	
E Y E	(c) VISUAL IMPAIRMENT (1) Is Insured totally blind? <input type="checkbox"/> YES <input type="checkbox"/> NO (2) If not totally blind, what was vision at last observation? With Glasses O. D. _____ O. S. _____ DATE _____ Without Glasses O. D. _____ O. S. _____ DATE _____ (3) What is the extent of any gross visual field defect? _____ (4) Can vision be improved by treatment, operation, or lenses? _____	

9. REMARKS

SIGNED _____	DATE _____
ADDRESS _____ No. & Street _____	City _____, M. D. _____ Zone _____ State _____