Sample Physician Statement for Premium Waiver Request

Patient Name:

Date of Birth:

Policy Number:

Attending Physician Statement

Diagnosis:

Date of Onset:

Current Treatment Plan:

Expected Duration of Disability:

Does the condition prevent the patient from performing work or major responsibilities?

Additional Comments:

Physician Name:

Practice Name & Address:

Phone:

Signature of Physician Date

Note: This statement is to be completed by the patient's attending physician to support a request for premium waiver due to disability or serious illness.