STATE OF CONNECTICUT

PHYSICIANS CERTIFICATE OF TOTAL AND PERMANENT DISABILITY

To be used only when accepted proofs of disability from Social Security Administration, Veteran's Administration, or other governmental offices are not obtainable.

I, _____, am familiar with the Social Security
(Physician's name)

Administration's requirements for establishing Total and Permanent Disability status.

In my opinion _____ meets or exceeds all
(applicant's name)

such requirements and is totally and permanently disabled.

To the best of my knowledge this disability began on _____.
(date of disability)

_____ _____
(Physician's signature) (date signed)

_____ _____
(print physician's name) (MD license # - **required**)