Exhibit 5G

PHYSICIAN'S STATEMENT – DISABILITY CLAIM

IMRF Form 5.42 (Rev. 05/11) *Please print or type (use Black Ink)*

Do NOT submit this form if the patient is still able to work.

Office visit notes/medical records must be attached to completed form.

Patient's Last Name	First	Middle Initial	Social Security Number
Rowe	James	J.	000 — 00 — 0000
Street (Mailing) Address	**City, State and ZIP**		**Phone Number**
123 Oak Street	Anywhere, IL 60000-1234		(000) 111-0022
Birth Date	**Patient's/Employee's Occupation**		
June 1, 1962	Maintenance Manager		

MANDATORY INFORMATION

*This section in the red box **MUST** be completed **fully**. If this information is not provided **the form will not be processed.***

Diagnosis and concurrent conditions.

ICD 9 Code(s) XXXXX00000-0000-0

Report of Treatments or Services. (*Failure to attach **Office Notes** will delay processing of this claim.*)

Date	Place (give name and address of hospital) - also list office visits	Description of Surgical or Medical Services Rendered
March 2, 2006	Anywhere Medical Center 123 Linden Street Anywhere, IL 60000	Open reduction and internal pixitro of transverse fracture

Date of next evaluation:

Patient was continuously disabled (unable to work) ***NOTE: Please be advised that this form is INVALID without a "From" Date below***

FROM March 2, 2006 **THROUGH** Present date

Is condition due to: Injury or sickness arising out of patient's employment? ☐ Yes ☒ No

Is disability due to an accident? ☒ Yes ☐ No **If yes**, date of accident: March 1, 2006

Did you recommend this person stop working? ☒ Yes ☐ No **If yes**, indicate date: March 2, 2006

Date symptoms first treated March 2, 2006 Describe any complications:

Patient ever had same or similar condition? ☐ Yes ☒ No **If yes**, indicate date(s) and describe:

Is patient now able to return to work in full duty capacity or with work restrictions? ☐ Yes, Full Duty ☒ Yes, w/Restrictions ☐ No

List any restrictions/limitations: Patient is unable to walk without crutches.

If yes, indicate return date April 25, 2006

If still disabled, what is principal cause of disability?

MANDATORY/VALID SIGNATURE, by licensed, practicing physician only.

Physician's Signature (*NOTE: Form will **not be processed** without Mandatory/Valid signature.*) Joe Medic M.D.

Date: March 5, 2006

Physician's Name	Degree/Specialty	Telephone Number
Dr. Joe Medic	M.D.	(000) 000-0000
Street (Mailing) Address	**City, State and ZIP**	**Fax Number** (000) 000-0000
123 Pine Street	Anywhere, IL 60000	Email Address: jmedic@anywhere.com

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