

LONG TERM DISABILITY QUESTIONNAIRE

INSURED'S INFORMATION

Name: _____

Address: _____

Telephone Number: _____

Facsimile Number: _____

MEDICAL INFORMATION

Medical Condition(s): _____

Treating/Consulting Physician(s): _____

Date of Onset of Condition: _____

EMPLOYER INFORMATION

Name: _____

Address: _____

Position: _____

Length of Employment: _____

POLICY INFORMATION

Employee Benefit: Yes No

Private Policy: Yes No

Effective Date of Policy: _____

Policy Number: _____

Claim Number: _____

Name of Insurer: _____

Claims Handler: _____

Address: _____

Telephone Number: _____

Facsimile Number: _____

SHORT TERM DISABILITY BENEFITS

Date Applied For: _____

Approved/Denied:

Yes **Date Benefits Began** _____ **Date Benefits Ended** _____

Reason for Termination of Benefits: _____

No **Date Benefits Denied** _____

Reason for Denial of Benefits: _____

Appealed: Yes No **Date Appealed:** _____

LONG TERM DISABILITY BENEFITS

Date Applied For: _____

Approved/Denied:

Yes **Date Benefits Began** _____ **Date Benefits Ended** _____

Reason for Termination of Benefits: _____

No **Date Benefits Denied** _____

Reason for Denial of Benefits: _____

Appealed: Yes No **Date Appealed:** _____

STATE DISABILITY BENEFITS

Date Applied For:

Approved/Denied:

Yes **Date Benefits Began** _____ **Date Benefits Ended** _____

Reason for Termination of Benefits: _____

No **Date Benefits Denied** _____

Reason for Denial of Benefits: _____

Appealed: Yes No **Date Appealed:** _____

SOCIAL SECURITY DISABILITY BENEFITS

Date Applied For: _____

Approved/Denied:

Yes **Date Benefits Began** _____ **Date Benefits Ended** _____

Reason for Termination of Benefits: _____

No **Date Benefits Denied** _____

Reason for Denial of Benefits: _____

Appealed: Yes No **Date Appealed:** _____

Add any additional comments concerning your claim: