Long-Term Disability Insurance Claim Form

1. Personal Information

Full Name

Date of Birth

Address

Phone Number

Email Address

2. Employment Information

Employer Name

Job Title

Employment Start Date

Work Address

Supervisor Name

3. Disability Information

Date Disability Began

Primary Diagnosis

Treating Physician

Physician Contact Information

Summary of Treatment

Expected Return to Work Date

4. Insurance Information

Policy Number

Claim Number (if known)

5. Authorization and Signature

I certify that the information provided is true and correct to the best of my knowledge.

Claimant Signature

Date