Mental Health Disability Insurance Claim Form

Personal Information

Full Name

Date of Birth

Address

Phone Number

Email Address

Policy Number

Employment Information

Employer Name

Occupation

Last Day Worked

Employment Status

Medical Information

Diagnosis

Date Symptoms Began

Treating Provider Name

Provider Address

Treatment Details

Claim Details

Reason for Claim

Duration of Absence (if known)

Additional Comments

Authorization & Signature

☐ I certify that the information provided is true and complete.

Signature

Date