Residual Disability Benefit Claim

Policyholder Information

Full Name

Date of Birth

Policy Number

Contact Number

Email

Address

Disability Details

Date Disability Began

Description of Disability

Treating Physician's Name

Physician's Contact

Employment Information

Occupation

Employer Name

Employer Contact

Monthly Income Before Disability

Monthly Income After Disability

Current Work Status

- [ ] Part-time
- [ ] Reduced Duties
- [ ] Other

Work Capacity Description

Additional Information

Supporting Documents (list)

Additional Notes

Declaration & Signature

Date

Signature