Long-Term Disability Insurance Claim Statement

Personal Information

Full Name

Date of Birth

Address

Phone Number

Email

Policy Number

Employment Information

Employer Name

Job Title

Employment Start Date

Employment Status

Last Day Worked

Disability Details

Primary Diagnosis / Condition

Date of Disability Onset

Cause of Disability (Describe)

Treating Physician(s)

Treatment Details

Other Income Sources

Are you receiving any other disability or income benefits?

If yes, please provide details

Additional Information

Additional Comments

Signature

Date