

Mental Health Disability Insurance Claim Statement

1. Personal Information

Full Name

Date of Birth

Policy Number

Contact Number

Email Address

Address

2. Employment Information

Employer Name

Job Title

Start Date

Current Work Status

Last Day Worked

3. Details of Disability

Primary Mental Health Diagnosis

How does this condition affect your ability to work?

Date Symptoms First Appeared

Date Diagnosed

4. Healthcare Provider Information

Treating Doctor / Mental Health Professional

Practice Name

Contact Number

Last Consultation Date

Treatment(s) Received

Medications Prescribed

5. Additional Information

Other relevant information or comments

6. Declaration

Signature

Date