Supplemental Disability Insurance Claim Statement

1. Personal Information

Full Name

Date of Birth

Policy Number

Address

Phone

Email

2. Claim Details

Date of Injury/Illness

Type of Disability

Is condition work-related?

Description of disability (include symptoms, diagnosis, and date symptoms began)

3. Employment Information

Employer Name

Occupation/Job Title

Last Day Worked

Duties unable to perform

4. Physician Information

Physician Name

Phone

Address

Dates of Treatment

5. Additional Information

Any other insurance coverage?

Notes or comments

6. Authorization & Signature

Signature

Date