Disability Insurance Claim Statement for Chronic Illness

Personal Information

Full Name

Date of Birth

Policy Number

Address

Phone Number

Email Address

Illness Details

Name of Chronic Illness

Date of Diagnosis

Attending Physician

Physician's Contact

Description of Symptoms

Treatment Plan

Employment Information

Current Employer

Job Title

Date Last Worked

Nature of Work Limitation

Additional Information

Other Relevant Information

Date

Signature