

Long-Term Disability Insurance Claim Statement

Personal Information

Full Name

Date of Birth

Social Security Number

Address

Phone Number

Email Address

Employment Information

Employer Name

Job Title

Date of Hire

Date Last Worked

Disability Information

Nature of Disability

Date of Diagnosis

Treating Physician

Description of Disability and How it Limits Work

Other Income

Are you receiving income from other sources? (e.g., Workers' Comp, Social Security)

If yes, provide details

Authorization & Signature

I hereby certify that the above information is true and complete to the best of my knowledge.



Signature

Date