Permanent Total Disability Claim Statement

Personal Information

Full Name

Date of Birth

Policy Number

Address

Phone Number

Email Address

Disability Details

Date Disability Commenced

Nature and Cause of Disability

Is the Disability Permanent and Total?

Has the disability prevented you from working? If yes, explain:

Name and Address of Treating Physician

Date First Seen by Physician

Employment Details

Occupation at Time of Disability

Employer Name

Employer Address

Last Date Worked

Other Insurance

Are there other insurance policies covering this disability?

If yes, list insurer(s) and policy number(s)

Declaration & Authorization

I declare the information provided above is true and complete to the best of my knowledge.

Signature

Date