Residual Disability Benefits Claim Statement

Personal Information

Full Name

Date of Birth

Policy Number

Contact Number

Address

Claim Details

Date Disability Began

Diagnosis

Treatment Received

Attending Physician

Work Information

Occupation

Employer

Description of Duties

Gross Monthly Income Before Disability

Gross Monthly Income After Disability

Statement

Please explain how your disability affects your ability to work:

Authorization

Signature

Date