Long-Term Disability Insurance Application

Personal Information

Full Name

Date of Birth

Social Security Number

Address

City

State

Zip Code

Phone Number

Email Address

Employment Information

Employer Name

Occupation/Job Title

Employer Address

Employer Phone

Employment Start Date

Annual Income

Disability Details

Type of Disability

Date Disability Began

Description of Disability

Treating Physician

Physician Phone

Treatment Received

Insurance Details

Do you have existing long-term disability insurance?

If yes, please provide details

Authorization & Signature

Signature

Date