

DISABILITY INFORMATION FORM

Personal Information

Name: _____ Year of Birth: _____
Spouse's name (optional): _____
Address (optional): _____
Phone (optional)– Home: _____
Cell: _____
Other: _____

Employer (name and address): _____

Annual salary or monthly wages for the year prior to your disability: _____

Insurance Information

Insurance Company: _____
Type of insurance policy: _____ Accident and Dismemberment _____ Life Insurance
_____ Short Term Disability _____ Long Term Disability _____ Pension
Amount of monthly benefit paid by insurance company _____
Is the insurance company claiming an overpayment? _____ If so, how much? _____
Do you have a copy of the insurance policy? _____
What is your illness or injury that gives rise to your disability claim? _____

Why has the insurance company denied or terminated your benefits? _____

Social Security Disability Benefits

Receiving? _____ How much? _____ When received? _____ On appeal? _____

Education ___ Less than High School ___ High School Diploma/GED ___ Some College
 ___ College Degree ___ Graduate Degree