DISABILITY INFORMATION FORM – STD/LTD/ID

Today's Date_____

PERSONAL INFORMATION

CLIENT	
NAME	
ADDRESS	
TELEPHONEs # (WORK /home)	
CELL PHONE	
PAGER #	
EMAIL ADDRESS	
DATE OF BIRTH	
SOCIAL SECURITY #	
DRIVER'S LICENSE #	
EMAIL ADDRESS	
SPOUSE	
NAME	
TELEPHONE # (WORK)	
TELEPHONE # (HOME)	
DATE OF BIRTH	
SOCIAL SECURITY #	
OCCUPATION	
EMPLOYER	
EMAIL ADDRESS	
PRIOR SPOUSES	
NAME	
ADDRESS	
TELEPHONE # (WORK)	
TELEPHONE # (HOME)	
MARRIAGE DATE	
DIVORCE DATE	
CHILDREN	
CHILDREN	
NAMES:	
DATES OF BIRTH	
ADDRESS	
CPA:	
NAME	
ADDRESS	
TELEPHONE #	
INCOME (State Your Income for the 5 years Prior to Disability) Provide Income Tax Returns, both Corporate & Individual for these years.	
YEAR	INCOME

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BANKRUPTCY (If you have filed bankruptcy, provide the following)					
Filing Date	Case #	Discharge Date	Attorney's Name	Attorney's Address	Chapter

Was your Disability claim listed as an asset in the Bankruptcy Action?

Was your bankruptcy attorney advised of the possibility of a disability claim or law suit involving your disability policy?

CONVICTIONS OR LAWSUITS

Have you ever been convicted of a felony? If so, explain.

Have you ever been a party to a law suit? If so, list the following.

Plaintiff	Defendant	Case#	Venue	Status?

EMPLOYMENT HISTORY FOR LAST 15 YEARS

Occupation at time of Disability?

Employer at time of Disability?

Duties at time of Disability?

Salary at time of Disability?

EMPLOYER	EMPLOYMENT DATES	JOB TITLE	DUTIES

EDUCATIONAL BACKGROUND (Including High School)			
School	Address (City, State)	Attendance Dates	Degree

CREDIT CARD/FINANCIAL INFORMATION Please contact TRW at (800) 682-7654 to request a current run of your credit history. This should then be provided to this office.		
Credit Card #	Company Name	Address

BANKS			
Account #	Savings or Checking	Bank Name	Address

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If you have applied for a loan since becoming disabled, provide this office with a copy of each and every such loan application.

Provide all bank statements & stock investments since the onset of your disability.

CURRENT DISABILITY INSURANCE POLICIES

Company Name	Policy #	Issue date	Monthly Benefit & Benefit Period	Date of Application

Provide this office with a copy of each and every Disability Insurance Policy and application.

CURRENT LIFE INSURANCE POLICIES

Company Name	Policy #	Issue date	Monthly Benefit	Waiver of Premium?

Provide this office with a copy of each and every Life Insurance Policy and application.

DENIED INSURANCE APPLICATIONS

Company Name	Policy Type (Life, DI)	Denial Date	Reason

If you received disability benefits for a period of time and was later terminated, from what period of time did you receive benefits?

If you received disability benefits, how much did you receive each month?

What was the reason given for termination of benefits?

Have you filed an Appeal for termination of benefits?

Have you exhausted all of your administrative remedies with the disability insurer?

What is the date of the last letter you received from your disability insurer?

SOCIAL SECURITY/STATE DISABILITY/WORKER'S COMPENSATION

Have you applied for Social Security? If so, supply all documents to this firm.

Are you currently being represented by an attorney? If so, provide name and address to this firm.

Have you applied for State Disability? If so, supply all documents to this firm.

Have you applied for Workers' Compensation? If so, supply all documents to this firm.
Are you currently being represented by an attorney? If so, provide name and address to this firm.

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DISABILITY			
Date of Disability? Cause of Disability? Doctor Certifying Disability?			
OCCUPATIONAL DUTIES AT THE TIME OF DISABILITY			
Duty	% of Time Performed Weekly	Currently Able to Perform	If not, why not?
CURRENT MEDICATIONS			
Medication	Dosage	Side Effects	Prescribed By:

If there is not enough room on the questionnaire, please write the remainder of the information on the back of the appropriate page and make a notation that there is additional information on the back page, so that we know to review the back page.

If there is other information regarding your disability and/or claim that was not covered in this questionnaire that you feel is important, please describe that information on this sheet in the space below or on the back of this page.

Thank you.

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MEDICAL

Treating Sources:

Name:	Name:
Add:	Add:
Tel:	Tel:
Period of Treatment:	Period of Treatment:
Type of Treatment: ☐ attending ☐ consultant	Type of Treatment: ☐ attending ☐ consultant
☐ clinic ☐ hosp. Inpatient ☐ hosp. OPD	☐ clinic ☐ hosp. Inpatient ☐ hosp. OPD
☐ Emerg. Rm. ☐ Diagnostic	☐ Emerg. Rm. ☐ Diagnostic
Special Instructions/Info:	Special Instructions/Info:

Name:	Name:
Add:	Add:
Tel:	Tel:
Period of Treatment:	Period of Treatment:
Type of Treatment: ☐ attending ☐ consultant	Type of Treatment: ☐ attending ☐ consultant
☐ clinic ☐ hosp. Inpatient ☐ hosp. OPD	☐ clinic ☐ hosp. Inpatient ☐ hosp. OPD
☐ Emerg. Rm. ☐ Diagnostic	☐ Emerg. Rm. ☐ Diagnostic
Special Instructions/Info:	Special Instructions/Info:

Name:	Name:
Add:	Add:
Tel:	Tel:
Period of Treatment:	Period of Treatment:
Type of Treatment: ☐ attending ☐ consultant	Type of Treatment: ☐ attending ☐ consultant
☐ clinic ☐ hosp. Inpatient ☐ hosp. OPD	☐ clinic ☐ hosp. Inpatient ☐ hosp. OPD
☐ Emerg. Rm. ☐ Diagnostic	☐ Emerg. Rm. ☐ Diagnostic
Special Instructions/Info:	Special Instructions/Info:

Name:	Name:
Add:	Add:
Tel:	Tel:
Period of Treatment:	Period of Treatment:
Type of Treatment: ☐ attending ☐ consultant	Type of Treatment: ☐ attending ☐ consultant
☐ clinic ☐ hosp. Inpatient ☐ hosp. OPD	☐ clinic ☐ hosp. Inpatient ☐ hosp. OPD
☐ Emerg. Rm. ☐ Diagnostic	☐ Emerg. Rm. ☐ Diagnostic
Special Instructions/Info:	Special Instructions/Info:

Name:	Name:
Add:	Add:
Tel:	Tel:
Period of Treatment:	Period of Treatment:
Type of Treatment: ☐ attending ☐ consultant	Type of Treatment: ☐ attending ☐ consultant
☐ clinic ☐ hosp. Inpatient ☐ hosp. OPD	☐ clinic ☐ hosp. Inpatient ☐ hosp. OPD
☐ Emerg. Rm. ☐ Diagnostic	☐ Emerg. Rm. ☐ Diagnostic
Special Instructions/Info:	Special Instructions/Info: