# Long Term Disability Questionnaire

**EMPLOYEE'S STATEMENT (ALL QUESTIONS MUST BE ANSWERED TO AVOID DELAY)**

**A. Information About You:**

| Last Name | First | Middle Initial | Social Security Number - - |
|---|---|---|---|
| Address (Street) | City | State/Province | Zip |
| Telephone Number ( ) - | Date of Birth MO/DAY/YEAR | Male Single Widowed<br>Female Married Divorced | |

Your Employer (include division, if applicable)

When your disability began, did you have more than one employer? Yes No. If "Yes," please provide the name, address, and phone number of that employer, and indicate the dates when you worked.

| Next to each activity, please place one of the following numbers that most accurately reflects your ability/inability to perform each: **1** = I can perform this activity independently; **2** = I can perform this activity in a limited capacity or with the use of equipment or adaptive devices; **3** = I cannot perform this activity. | __ Walk __ Bend __ Stoop<br>__ Squat __ Kneel<br>__ Climb/Balance __Crawl<br>__ Reach Above Shoulders<br>__ Lift/Carry (Max lbs:___ )<br>__ Use of Memory __ Other | Repetitive Tasks as Follows:<br>__ Push/Pull<br>__ Use of Right Hand<br>__ Use of Left Hand<br>__ Use of Right Foot<br>__ Use of Left Foot |
|---|---|---|

Please provide further detail for any limitations noted above:

Please indicate the extent of your formal education (Circle One):
Grade/Middle/High School: 1 2 3 4 5 6 7 8 9 10 11 12
College: 1 2 3 4 Masters ____________________ Ph.D. ________________________
Trade School: __________________________ Current Occupational License(s): ____________________________
Briefly describe your past work experience for the last 20 years (begin with your most recent job):

| Job Title | Duties | Years Worked |
|---|---|---|
| (a) | | |
| (b) | | |
| (c) | | |
| (d) | | |

**B. Information About Your Family:**

Spouse's Name (Last, First):

| Spouse's Social Security Number | Date of Birth MO/DAY/YEAR | Is your spouse employed? Yes No | Retired? Yes No |
|---|---|---|---|

Do you have any children under Age 19? Yes No (If "Yes" list name and date of birth for each child):

Do you have any children with disabilities (regardless of age)? Yes No (If "Yes" list name and date of birth for each child):

**C. Information About Physicians and Hospitals:** First medical attention was given by (complete below):

| Doctor's Name | Telephone No:<br>Fax No: | Specialty: |
|---|---|---|
| Address (Street, City, State, Zip) | | Dates Seen:<br>From To |



**SEND COMPLETED FORMS TO: Disability Insurance Specialists PO Box 29, Bloomfield, CT 06002**
**Fax # (860) 769-6986 Phone # 1-800-722-9680**

## C. Information About Physicians and Hospitals (*continued*):

Have you consulted any other physicians or been hospitalized in the past three (3) years? Yes No
If "Yes," complete the following concerning your past treatment (attach separate sheet, if needed):

| Doctor's Name | Telephone No:<br>FAX No: | Specialty |
|---|---|---|
| Address (Street, City, State, Zip) | | Dates Seen<br>From To |
| Hospital | | |
| Address (Street, City, State, Zip) | | Dates of Confinement<br>From To |

## D. Other Income

Please provide information regarding the other Income benefits you have received/are receiving, or are eligible to receive during your disability (complete the Information requested):

| Source of Income | Amount (week/month) | Date claim filed | Date payments began | Date payments ended |
|---|---|---|---|---|
| Social Security (Retirement) | $____/____ | | | |
| Social Security (Disability) Primary: | $____/____ | | | |
| Dependents: | $____/____ | | | |
| Sick Pay/Salary Continuation | $____/____ | | | |
| Income from Work | $____/____ | | | |
| Worker's Compensation | $____/____ | | | |
| State Disability | $____/____ | | | |
| Pension (Retirement) | $____/____ | | | |
| Pension (Disability) | $____/____ | | | |
| Short Term Disability | $____/____ | | | |
| Unemployment | $____/____ | | | |
| No-Fault Insurance | $____/____ | | | |
| Other (Include Individual or Group Benefits and List Source) | $____/____ | | | |

## E. Signature

The statements contained in this application for Long Term Disability Benefits are true and complete to the best of my knowledge and belief. With the exception of any source(s) of income reported above in Section D of this form, I certify that I have not received and am not eligible to receive any source of income, except for my Disability Income. Further, I understand that should I receive income of any kind or perform work of any kind, I must report the details to Disability Insurance Specialists immediately.

X______________________________
Signature of the Employee



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**F. Reimbursement Election**

Long Term Disability (LTD) benefits will be reduced by the amount of any Other Income benefits you are eligible to receive. Please refer to your Policy for a full description of Other Income benefits. Some of these Other Income benefits may be awarded to you in a lump sum at a future date after you have begun to receive your LTD benefits.

If your LTD benefit is calculated without a reduction for Other Income benefits and those benefits are later awarded on a retroactive basis, an overpayment of your LTD benefit could result. You may wish to avoid accumulation of a large overpayment by having us deduct an estimated Other Income benefit amount from your LTD benefit payments.

If I receive LTD benefits greater than those which should have been paid as a result of choosing either of the options indicated below, I understand that upon request, I will be required to immediately provided a lump sum repayment to Disability Insurance Specialists, LLC. Disability Insurance Specialists, LLC has the option to reduce or eliminate future LTD benefit payments in order to recover any overpayment balance that is not reimbursed. The Minimum Monthly Benefit may not apply in the case of an overpayment.

Please check one box below:

1. Please estimate the amount of monthly Other Income benefits and reduce my LTD benefit by this amount. Disability Insurance Specialists will adjust my monthly LTD benefit rate when they receive proof showing either the amount of Other Income benefits awarded or denial of Other Income benefits.

2. Please pay my monthly LTD benefits to me without any reductions for estimated Other Income benefits. I understand that this may result in an overpayment of my LTD benefits and will require that I immediately refund Associated Mutual a lump sum payment.

Name (please print) ______________________  Social Security Number ______________________

Signature ______________________  Date ______________________



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