



DISABILITY QUESTIONNAIRE

Name _____ Claim Number _____

SPECIAL NOTICE-Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **FOR OHIO ONLY**-Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

In order to assist us with the processing of your claim, please complete this questionnaire and return it to our office as soon as possible. If necessary, please use a separate sheet of paper to complete any of the survey items.

1. Describe, in your own words, what prevents you from working. _____

2. List the names and addresses of each doctor you see regularly. _____

3. List the name and address of any Vocational Rehabilitation. _____

4. List any/all medications that you take and the dosage. _____

5. If you have been confined in a hospital within the last 12 months, please list the name, address and the dates that you were confined.

Name of Hospital _____ Confined From _____ To _____
Complete Address _____
Reason _____

6. Please indicate any change in your condition since you stopped working.
_____ Improved _____ No Change _____ Worse

7. Please indicate any hobbies or interests that you had or still have. _____

8. Please indicate how many years of school you completed
Circle one: 1 2 3 4 5 6 7 8 9 10 11 12 College 1 2 3 4 Masters PhD
If you attended college, indicate your major: _____

Describe any technical training, business school education, or any type of license that you may have:

Mail Completed Form To: 2721 N. Central Ave. – Phoenix, AZ - 85004
Phone 800-585-5821 – Fax 602- 263-6993

