PUBLIC EMPLOYEES HEALTH PROGRAM LONG-TERM DISABILITY PROGRAM

560 East 200 South, Salt Lake City, Utah 84102-2004 – (801) 366-7583 – (800) 365-7347 Fax (801) 366-7321

ANY OCCUPATIONS DISABILITY QUESTIONNAIRE

Please complete this form, sign, date and return it to the above address. This information is important for continuing your Long-Term Disability benefits.

PERSONAL IDENTIFICATION

Name: Phone Number:

Address / City / State / Zip:

MEDICAL CARE INFORMATION (you may write on back if space is needed)

Have you received any inpatient hospitalization treatment during the past year? If yes, please list hospital, dates & condition(s) treated.

Please list current prescription medications and reason for prescription.

Has your health changed in the last year? If so, please explain.

Please list all doctors and specialists you have seen for your disabling condition(s) in the last year. List all details requested below. Please note that incomplete information can delay your review for ongoing benefits. You may write on back if space is needed.

Name & Specialty:	**Name & Specialty:**
Full Address:	**Full Address:**
Phone:	**Phone:**
Date of Last Visit:	**Date of Last Visit:**
Reason for Visit:	**Reason for Visit:**
Name & Specialty:	**Name & Specialty:**
Full Address:	**Full Address:**
Phone:	**Phone:**
Date of Last Visit:	**Date of Last Visit:**
Reason for Visit:	**Reason for Visit:**

Mark here if information is written on separate or back of any sheet ☐

DAILY ACTIVITY INFORMATION

Please check the appropriate box best describing yourself performing the following activities.

Activities of daily living	No assistance required	Occasional assistance required	Regular assistance required
Laundry			
Cooking / Meal preparation			
Eating			
Cleaning			
Grocery or other shopping			
Yard care			
Driving			
Bath / Shower			
Getting in /out of bed or chair			
Climbing stairs			
Toileting / Dressing			
Managing own finances			

HOBBIES / OUTSIDE ACTIVITIES / VOLUNTEER WORK

*Please list all activities in which you currently participate:

INCOME INFORMATION

Are you, your spouse, or dependents receiving Social Security benefits? _____ Yes _____ No
* If so, please list the monthly amounts below:

Self: $_____ Spouse: $_____ Each Dependent: $_____

If you have you applied for, appealed, requested, been awarded and/or received any retirement, Worker Compensation, Social Security, settlement, unemployment, etc. or other disability income, please list details below:

Have you participated in any paid work in the last year? _____ Yes _____ No
(This includes but is not limited to self-employment, sales, etc.)

* If so, please list source of income, dates of services and salary received below:

I certify that the above statements are true and complete to the best of my knowledge and that any falsification of information may result in the immediate cessation of all benefits. I understand I am required by statute to notify the LTD Program of any income, wages, awards, settlements, employment or ability to work, etc. and by failing to notify the Program timely all of my benefits may be terminated including but not limited to LTD, stipend, Life benefits and URS years of service accrual.

Signature of Claimant: _____ Date: _____