LONG-TERM DISABILITY PROGRAM

PO Box 1169, Salt Lake City, Utah 84110 – 801-366-7583 – 800-365-7347 Fax 801-366-7321

ALL 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 are receiving any retirement, Worker Compensation or other disability income, please list details _____

_____

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. I understand that any falsification of information may result in the immediate cessation of my benefits.

Signature of Claimant: _____ Date: _____