

SUPPLEMENTAL DISABILITY STATEMENT



PO Box 7466 Portland ME 04112-7466
Tel 888 299 2070 Fax 888 505 8550

Claimant's Name: _____ DOB: _____

1. Do you continue to be unable to work due to sickness or injury? Yes No

If no, on what date did you recover? _____ / _____ / _____

Are you currently working? Yes No If yes, please provide details: _____

Are you engaged in work activities without pay or in any volunteer activities? Yes No

If yes, please provide details: _____

2. Please describe your typical current daily activities: _____

If not working now, what about your situation/condition would have to change for you to be able to return to work?

3. Please list the names and dates of births of all of your dependents:

Dependent Name	Date of Birth	Dependent Name	Date of Birth

4. Provide the names, address and date you last saw the doctors who are treating you for your disability.

_____	_____	_____ / _____ / _____
Doctor's Name	Specialty	Date last seen
_____	_____	()
Doctor's Address	_____	Doctor's phone number
_____	_____	_____ / _____ / _____
Doctor's Name	Specialty	Date last seen
_____	_____	()
Doctor's Address	_____	Doctor's phone number
_____	_____	_____ / _____ / _____
Doctor's Name	Specialty	Date last seen
_____	_____	()
Doctor's Address	_____	Doctor's phone number

5. Please list any **restrictions* the doctor has placed on your activities: (**restrictions – what your doctor has advised you not to do*) _____

6. Please describe any **limitations* you have in your activities: (**limitations – what you feel you are unable to do because of your sickness or injury*) _____

7. Are you currently involved in a vocational rehabilitation program? Yes No

If yes, please provide a contact name and phone number: _____

Claimant Name: _____

8. Are you receiving or have you applied for:
(include benefits for you or any family)

9. Are you receiving, have you received or have you applied for any type of payment from any employer's retirement member plan? If so, complete:

	Receiving Payments	Amount \$	Applied or appealed, but no decision	Applied and claim was denied – no appeal pending		
Social Security Disability					Name of Employer:	
Social Security Retirement					If Monthly, Amount	\$
Family/Dependent Social Security Disability					Effective Date	
State Retirement						
Long Term Disability*					If Lump Sum, Amount:	\$
VA Disability					Date Received"	
Worker's Compensation						
Pension Benefits					If applied for only, give details:	
*Name, address & phone number of insurance company along with claim number of long term disability claim:						

Please be aware: **Any person who knowingly, and with intent to injure, defraud or deceive and insurance company, files a statement of claim containing any false, incomplete or misleading information, is guilty of a felony, and may be subject to imprisonment, fines, and civil damages.** **California:** Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison. **Colorado:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of Insurance within the department of regulatory agencies. **Florida:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree. **Kentucky:** Any person who knowingly, and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime. **New Jersey:** Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. **New York:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation. **Pennsylvania:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The above statements are true and complete to the best of my knowledge and belief. I hereby authorize any health care provider, physician, psychologist, hospital, insurance company, government agency or other entity presented with a copy of this authorization, to furnish **Unimerica Insurance Company, Unimerica Life Insurance Company of NY (New York only), United Healthcare Insurance Company of CT (Connecticut only) or their authorized representative, any and all information in their possession regarding my treatment, medical history, benefits or other applicable information regarding my disability**, this includes, but is not limited to information concerning HIV, AIDS and mental health information, and/or financial, consumer report, or any other non-medical information regarding me. All information submitted shall be used in conjunction with the evaluation of my claim for disability benefits. This authorization shall remain valid for 18 months from the date it is signed unless I revoke it in writing. A photocopy of this form will be as valid as the original.

Date: _____ / _____ / _____ Signature: _____

Address: _____ Phone: (____) _____ - _____