Disability RMS

Expertise • Performance • Brand Protection

Please return completed form to:

Disability Reinsurance Management Services, Inc.
300 Southborough Drive, Suite 200
South Portland, ME 04106-6914
Phone: (877) 254-0085
Fax (207) 766-3448

Please Return By: _______________

SUPPLEMENTARY PROOF OF LOSS
CLAIMANT'S STATEMENT

1. Full Name (Please Print) Address: Telephone: Home ________________ Mobile ________________ Email Address: ____	Date of Birth:	Policy No.(s): Social Security No.:

2. a. Cause of Disability:

   b. What is your current height: _____________ weight: _____________

3. Have you received medical attention since your last report? Yes ☐ No ☐

   If "Yes", list names and addresses of doctors and treatment dates. Please also provide names, addresses and treatment date of physical therapy providers if applicable (attach additional pages if necessary).

________________________________ ____
Name of Medical Provider Street
____
City, State, Zip Code
____________________ ____/____/_______ ____/____/______
Phone Last Appointment Next Appointment

________________________________ ____
Name of Medical Provider Street
____
City, State, Zip Code
____________________ ____/____/_______ ____/____/______
Phone Last Appointment Next Appointment

________________________________ ____
Name of Medical Provider Street
____
City, State, Zip Code
____________________ ____/____/_______ ____/____/______
Phone Last Appointment Next Appointment

________________________________ ____
Name of Medical Provider Street
____
City, State, Zip Code
____________________ ____/____/_______ ____/____/______
Phone Last Appointment Next Appointment

4. Have you been hospitalized or undergone surgery since your last report? Yes ☐ No ☐ If "Yes", list:

   a. Name and Address of Hospital:

   b. Dates of Confinement:

   c. Type of Surgery:

5. a. What are your present complaints?

b. Have you experienced any significant changes in the last 6-12 months? Yes ☐ No ☐

If yes, please explain.

c. Briefly describe your present daily activities.

6. a. Are you still unable to perform all the duties of your regular occupation? Yes ☐ No ☐

If "Yes", do you expect to return to your own or any occupation? Yes ☐ No ☐ When? ___/____/______
Month Day Year

b. Are you currently employed in any occupation on a full-time or part-time basis? Yes ☐ No ☐

If "Yes", date employment began: _____/____/______ Full-Time ☐ Part-Time ☐
Month Day Year

7. a. Are you now eligible for, have you applied for, or are you now receiving income benefits from:

Social Security Disability? Yes ☐ No ☐ applied ☐ approved ☐ denied ☐ under appeal ☐

Social Security Retirement? Yes ☐ No ☐ applied ☐ approved ☐ denied ☐ under appeal ☐

Any Other Income Benefits? Yes ☐ No ☐ applied ☐ approved ☐ denied ☐ under appeal ☐

b. If you have an attorney or advocate assisting you with your application for any of the above, please provide your attorney or advocate's name, address, and phone number.

c. If receiving any of the above, please give details including amounts received, effective date and name of the company, organization or government agency from which benefits are being received. Attach documentation or copies of awards that you have not previously provided.

Benefit Type	Amount	Effective Date	Provider Name & Address
Social Security Disability	$______________	______________	______________________________
Social Security Retirement	$______________	______________	______________________________
Workers' Compensation	$______________	______________	______________________________
Pension Disability	$______________	______________	______________________________
Regular Retirement	$______________	______________	______________________________
State Disability Benefits	$______________	______________	______________________________
No-Fault Auto Insurance	$______________	______________	______________________________
Unemployment Compensation	$______________	______________	______________________________
Other ____________________	$______________	______________	______________________________
__________________________	$______________	______________	______________________________

8. Have you ever served in the Armed Forces? Yes ☐ No ☐ If yes how long? _____________

The statements above are true and complete to the best of my knowledge.

____ _____/_____/______
Insured's Signature Date

Claim ID: **0901**