Disability RMS

Committed to a higher standard

Please return completed form to:

Disability Reinsurance Management Services, Inc.
One Riverfront Plaza
Westbrook, ME 04092-9700
Phone: (877) 254-0085
Fax: (207) 591-3048

Please return both pages by:_______________

SUPPLEMENTARY PROOF OF LOSS
LONG TERM DISABILITY - CLAIMANT'S STATEMENT

1. Insured's full name and address (Please Print) | Date of Birth | Policy No.(s) | Social Security No.

Home Telephone __________________ Employer's Telephone __________________

2. Cause of Disability:

3. Have you received medical attention since your last report? Yes ☐ No ☐ If "Yes", list:
   (a) Names of Doctors
   (b) Dates of Treatment

4. Have you been hospitalized or undergone surgery since your last report? Yes ☐ No ☐ If "Yes", list:
   (a) Name of Hospital
   (b) Dates of Confinement
   (c) Type of Surgery

5. (a) What are your present complaints?
   (b) Briefly describe your present daily activities:

6. Date disability began: _____/____/____
   Month Day Year

   (a) Are you still totally disabled and unable to perform all the duties of your regular occupation? Yes ☐ No ☐

   If "Yes" when do you expect to return to your regular occupation? _____/____/____ Month Day Year

   If "No" when did you return to your regular occupation? _____/____/____ Month Day Year

   (b) If partially disabled, when did you begin working at your regular occupation? _____/____/____ Month Day Year

   (c) What important occupational duties have you been unable to perform during such partial disability?

   (d) Are you now gainfully employed in other than your regular occupation? Yes ☐ No ☐

   If "Yes", date you commenced such duties: _____/____/____ Month Day Year

   (e) Briefly describe the job and nature of duties performed:

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

Social Security Disability	Social Security Retirement	Other Income Benefits:	Yes	No
Yes ☐ No ☐	Yes ☐ No ☐	Unemployment Compensation	☐	☐
		State Disability Benefits	☐	☐
		No-Fault Auto Insurance	☐	☐
☐applied	☐applied	Pension Disability	☐	☐
☐approved	☐approved	Regular Retirement	☐	☐
☐denied	☐denied	Worker's Compensation	☐	☐
☐under appeal	☐under appeal	Any other income benefit (Federal, State, VA, etc.)	☐	☐

(b.) If answer is "Yes", please give details including amounts received, effective date and name of company and organization or government agency from which benefits are being received. Attach documentation or copies of awards that you have not previously provided.

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

_________________________________ ____/____/______

Insured's Signature Date