beneva

Claimant's statement

Insurance Policy No. _____

1.Claimant's identification

☐ Mr. ☐ Mrs. ☐ Ms. _____ _____
First and last names — Last name at birth

Address: _____

_____

_____ _____ Y Y Y Y M M D D
Telephone — Cell phone — Date of birth

_____

Do you work: ☐ Full-time ☐ Part-time

No. of hours per week: _____

Employer: _____

Address: _____

Your occupation: _____

If you don't work, are you:

☐ retired

☐ a student

☐ unemployed

☐ other, specify: _____

2. Information Regarding Disability Claim Request

If a sickness: Diagnosis: _____ Date of onset of sickness: Y Y Y Y M M D D

If an accident: Type of injury: _____ Date of accident: Y Y Y Y M M D D

Date of cessation of activities or work: Y Y Y Y M M D D

Describe in detail the circumstances of the accident (use another sheet, if necessary): _____

_____

_____

_____

_____

Have you stayed in a medical facility or hospital? ☐ Yes ☐ No

If yes, which: _____ From Y Y Y Y M M D D to Y Y Y Y M M D D

Address: _____

Please complete your statement on the other side of this form.

Information regarding your daily activities

To help us evaluate your request, please only identify the activities that concern you:

Activities	What activities did you perform before your disability?	Describe how your activities were or are now performed since your disability?		
Preparing meals	☐	☐ I can do it alone	☐ I can do it with help	☐ Not able to do it
Eating	☐	☐ I can do it alone	☐ I can do it with help	☐ Not able to do it
Cleaning or dressing yourself	☐	☐ I can do it alone	☐ I can do it with help	☐ Not able to do it
Doing dishes/making the bed/laundry	☐	☐ I can do it alone	☐ I can do it with help	☐ Not able to do it
Going shopping	☐	☐ I can do it alone	☐ I can do it with help	☐ Not able to do it
Managing your budget	☐	☐ I can do it alone	☐ I can do it with help	☐ Not able to do it
Vacuuming/cleaning	☐	☐ I can do it alone	☐ I can do it with help	☐ Not able to do it
Driving an automobile	☐	☐ I can do it alone	☐ I can do it with help	☐ Not able to do it
Snow removal/lawn mowing	☐	☐ I can do it alone	☐ I can do it with help	☐ Not able to do it
Moving around the house	☐	☐ I can do it alone	☐ I can do it with help	☐ Not able to do it
Walking/going outside	☐	☐ I can do it alone	☐ I can do it with help	☐ Not able to do it
Going dancing, bowling	☐	☐ I can do it alone	☐ I can do it with help	☐ Not able to do it
Reading/television/solitaire games	☐	☐ I can do it alone	☐ I can do it with help	☐ Not able to do it
Going skiing/bicycling/golfing	☐	☐ I can do it alone	☐ I can do it with help	☐ Not able to do it
Movie/card club outings	☐	☐ I can do it alone	☐ I can do it with help	☐ Not able to do it
Using a computer	☐	☐ I can do it alone	☐ I can do it with help	☐ Not able to do it
Managing your medication	☐	☐ I can do it alone	☐ I can do it with help	☐ Not able to do it
Volunteering (specify)		☐ I can do it alone	☐ I can do it with help	☐ Not able to do it
Other activities not listed		☐ I can do it alone	☐ I can do it with help	☐ Not able to do it

Have you resumed your activities or returned to work? ☐ Yes ☐ No

If yes, since when? Y Y Y Y M M D D If no, scheduled date of return? Y Y Y Y M M D D

Name and address of your current family doctor: _____

_____

If you have been a patient of this family doctor for less than five (5) years, provide the name and address of your previous family doctor:

_____

_____

If a family member helped you complete this statement and you have authorized them to discuss your file with us, please give the following information:

_____ _____ _____

First and last names | Relationship with you | Telephone

I, the undersigned, hereby declare that the answers to the questions above have been properly recorded and that they are whole, complete and true, to the best of my knowledge. I declare them to have the same value as if they were taken under oath.

X _____ Y Y Y Y M M D D

Claimant's signature | Date