Disability Benefits Reinstatement Request Form

Personal Information

Full Name

Date of Birth

Social Security Number

Phone Number

Mailing Address

Benefit Information

Previous Claim Number

Type of Disability Benefit

Select...

Date Benefits Ended

Reason for Reinstatement Request

Please provide an explanation for your reinstatement request:

Certification

☐ **I certify that the information provided is true and accurate to the best of my knowledge.**

Signature

Date