# Supplemental Health Statement for Disability Insurance

## Personal Information

Full Name

Date of Birth

Address

Phone Number

Policy Number

## Health Information

Current State of Health

Have you been treated for any medical condition in the past 5 years? If yes, please describe.

Current Medications (if any)

Name and Address of Primary Physician(s)

Hospitalizations or Surgeries in the Past 5 Years (include dates and reasons)

Do you have other disability insurance policies? If yes, provide details.

## Additional Information

Other Relevant Information or Comments

**Declaration:**

I hereby declare that the information provided above is accurate and complete to the best of my knowledge. I understand that providing false information may result in denial of benefits or cancellation of my policy.

Signature

Date