Authorization for Income Verification
Disability Insurance Claim Processing

Applicant Information

Full Name: _____

Date of Birth: _____

Address: _____

Phone Number: _____

Policy Number: _____

Employer Information (if applicable)

Employer Name: _____

Employer Address: _____

Authorization

I hereby authorize my current and past employers, financial institutions, and any other entities or persons holding my income information to release and disclose such details to the disability insurance provider for the purpose of claim assessment and processing.

This authorization is valid for the duration of my claim evaluation and may be revoked in writing at any time. A copy or facsimile of this authorization shall be as valid as the original.

_____

Signature

_____

Date