

GINSBERG LAW OFFICES, P.C.
LONG/SHORT TERM DISABILITY QUESTIONNAIRE

Personal Information

Your full name: _____ SS# _____

Address: Street _____

City: _____ State: _____ Zip: _____

Home Phone _____ Pager _____ E-mail: _____

How did you learn about Ginsberg Law Offices? _____

If we had to reach you in an emergency, who should we call?

Emergency name _____ Phone #: _____

Birth date: _____ Age: _____

Case Information

What type of case do you have?

Short Term Disability (STD) _____ Long Term Disability (LTD) _____ Soc. Security _____

Who is your Employer? _____

Who is the Disability Insurance Carrier? _____

Name of Adjuster: _____

Policy Number: _____

Claim Number: _____

What was your occupation as of your date of disability? _____

Describe your regular job duties: _____

Date Claim Filed: _____

Date Claim Denied/Terminated: _____

MEDICAL CONDITIONS:

Please list your health problems which make you unable to work (list them in order of severity):

- 1. _____
- 2. _____
- 3. _____
- 4. _____

MEDICAL TREATMENT:

Are you presently under doctor's care: Yes _____ No _____

Is there one doctor who knows your case the best and would be willing to help us prove that you are unable to work? Which doctor? _____

Please list the doctors that have treated you:

Doctor's name		Specialty	
Address:	City	State/Zip	
First seen:	Last seen	Next appt.	
Describe treatment			

Doctor's name		Specialty	
Address:	City	State/Zip	
First seen:	Last seen	Next appt.	
Describe treatment			

Doctor's name		Specialty	
Address:	City		State/Zip
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Describe treatment			

Doctor's name		Specialty	
Address:	City		State/Zip
First seen:	Last seen	Next appt.	
Describe treatment			

Hospitals

Please list all of the hospitals that have treated you for conditions related to your current disability:

Hospital name		Specialty	
Address:	City	State/Zip	
First seen:	Last seen	Next appt.	
Describe treatment (in patient/out patient/emergency room):			

Hospital name		Specialty	
Address:	City	State/Zip	
First seen:	Last seen	Next appt.	
Describe treatment (in patient/out patient/emergency room):			

Hospital name		Specialty	
Address:	City	State/Zip	
First seen:	Last seen	Next appt.	
Describe treatment (in patient/out patient/emergency room):			

Have you ever had surgery? If so, please provide date and description:

Type of surgery			
Date of surgery	Name of hospital:		
Surgeon:			
Was surgery successful:			

Please provide any additional information that you think may assist us with your case:

Please attach a copy of your STD/LTD Policy Manual (if you do not have one, request one from your employer) and copies of any and all correspondence you may have received.