PERSONAL PROFILE EVALUATION

PLEASE PRINT

Please submit this form to:
The Union Labor Life Insurance Company
300 Southborough Drive, Suite 200
S Portland, ME 04106-6914
Toll free: (877) 254-0085 • Fax: (207) 766-3448

Claimant name: Policy number:

Claimant: Please complete this form to the best of your ability. If you have difficulty writing or are unable to complete the form, please have a family member assist you and sign their name under the claimant signature line on the other side of this form.

Please describe your current condition and how it affects your ability to work:

Has there been a change in your condition in the past 12 months? ○ Yes ○ No

If yes, please describe:

Briefly describe your activities during the course of a typical day:

What kind of hobbies or social/community activities did you engage in prior to the disability?

Have you continued to engage in any of these activities since you became disabled? ○ Yes ○ No

Do you presently continue with any of these activities? ○ Yes ○ No

If yes, please list the hobbies or social/ community activities and indicate how often you participate in them:

Activity: Frequency:

Activity: Frequency:

Activity: Frequency:

Have you engaged in any work activity (including self-employment) in the past 12 months or plan to engage in any work activity? ○ Yes ○ No

If yes, please indicate the name and address of the employer, date of employment, gross monthly earnings and essential duties:

Print employer’s name: Date of employment:

Address:

City: State: Zip:

Essential duties: Gross monthly earnings:

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PERSONAL PROFILE EVALUATION

SIDE 2

Please submit this form to:
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Claim Service Center
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S Portland, ME 04106-6914
Toll free: (877) 254-0085 • Fax: (207) 766-3448

Please list all forms of monthly and/or weekly other income you are currently receiving including: social security disability or retirement benefits for yourself and any children, pension, no fault accident insurance, any other group or individual disability benefits.

Type:	Effective date:	Monthly amount:

Please indicate the extent of your formal education (circle one): 1 2 4 5 6 7 8 9 10 11 12 13 14 15 16+

Do you have a high school diploma? o Yes o No   Have you attended vocational schools? o Yes o No

Did you attend college? o Yes o No   If yes, number of years:

Degree(s) received: Major fields of study:

Please list prior jobs you have had in the past 10 years:

Occupation:	Dates:	Duties:

Please list all the physicians you are currently treating with including their address and phone number.

Name: Phone:
Address: City: State: Zip:

Name: Phone:
Address: City: State: Zip:

Name: Phone:
Address: City: State: Zip:

Name: Phone:
Address: City: State: Zip:

In the event your spouse needs to contact us, please provide the following for verification purposes. o Check here if not married

Name of your spouse: Spouse's date of birth:

Claimant signature: Date:
X

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