SOLUTIONS FOR THE UNION WORKPLACE

RESOURCE QUESTIONNAIRE UPDATE

To assist us in the evaluation of your disability claim, please complete this questionnaire and return to us in the enclosed envelope. The information that you provide will assist us in our continuation of the evaluation of your disability claim and also in determining rehabilitation opportunities for which you may be eligible.

Name:	Address:
Social Security Number:	Telephone Number:
Date of Birth:	Spouse's Date of Birth:
Dependent Children's Date of Birth:	

1. Describe in your own words what prevents you from performing YOUR occupation at this time.

2. Describe in your own words what prevents you from engaging in ANY gainful employment at this time.

3.Height: 4. Weight: 5. **Right** or **Left** Handed: 6. Tobacco User?: Quantity?

7. List the name and address of the health care provider(s) you see regularly (include frequency). Please use the other side of this page to list additional providers, if necessary.

Provider's Name/Specialty	Telephone: Fax:
Address:	Date of Last Visit: Date of Next Visit:

Provider's Name/Specialty	Telephone: Fax:
Address:	Date of Last Visit: Date of Next Visit:

8. Please indicate the chores you perform on a regular basis:

Cook ☐ Shop ☐ Laundry ☐ Dust ☐ Vacuum ☐ Dishes ☐ Child Care ☐

Garden/Lawn Care ☐ Shovel Snow ☐ Care Maintenance ☐ Other:

9. Do you go for walks or exercise? Yes ☐ No ☐ If yes, what type of exercise and the frequency?

10. What difficulties, if any, do you have sleeping?

_____

11. Do you have a valid driver's license? Yes ☐ No ☐

12. Do you still drive? Yes ☐ No ☐
If no, please explain why you are restricted from driving and how you are able to attend appointments or shopping?

_____

13. Please provide the activities you attend and for how long? (school, therapy , exercise, rehabilitation, etc.)

_____

14. What do you do for fun? (TV, read, internet, crafts, fishing, etc) How frequently?

Do you own a computer? Yes ☐ No ☐ email address:_____

_____

15. From the date you have been approved for disability benefits, have you attempted to return to work or are you currently working? Yes ☐ No ☐ If yes, please indicate the <u>period of time</u>, and the <u>job duties</u> and the <u>employer</u>.

If no, are you interested in returning to work? Yes ☐ No ☐

NOTICE: Any person who knowingly and with intent to defraud or deceive any insurance company or other person files a statement of claim containing any materially false or misleading information, or conceals for the purpose of misleading, information concerning any fact material thereto **COMMITS A FRAUDULANT INSURANCE ACT, WHICH IS A CRIME** and in certain states, a felony. Penalties may include imprisonment, fines, and denial of insurance and civil damages. In New York, there are also civil penalties not to exceed $5,000 and the stated value of the claim for each such violation.

Under penalties of perjury, I certify that the above statements and answers are true and correct to the best of my knowledge and belief.

Claimant's Signature: _____ Date: _____