

# Mutual of Detroit Applicant Disability Questionnaire

Proposed Insured: \_\_\_\_\_ Policy Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

## REMARKS

- |   | YES                      | NO                       |                                    |
|---|--------------------------|--------------------------|------------------------------------|
| 1) Are you currently disabled?  | <input type="checkbox"/> | <input type="checkbox"/> |                                    |
| 2) When did you become disabled?  |                          |                          |                                    |
| 3) Please describe your disability:   |                          |                          |                                    |
| 4) Is this disability permanent?  | <input type="checkbox"/> | <input type="checkbox"/> |                                    |
| <i>If "No," when are you likely to return to work?</i>  |                          |                          |                                    |
| 5) Are you currently under medical treatment for your disability?   | <input type="checkbox"/> | <input type="checkbox"/> | <i>(If "Yes," please describe)</i> |
| 6) Have you been advised to have any surgery or other medical treatment which has not yet been completed? | <input type="checkbox"/> | <input type="checkbox"/> | <i>(If "Yes," please describe)</i> |
| 7) Are you currently receiving SSI?   | <input type="checkbox"/> | <input type="checkbox"/> |                                    |
| <i>If "Yes," what was the reason for your award?</i>  |                          |                          |                                    |
| 8) In addition to work restrictions, what other limitations are you advised to follow?                    |                          |                          |                                    |

I represent that I have read and understand all the statements and answers in this questionnaire and that they are true and complete to the best of my knowledge. I agree that the statements and answers given in this questionnaire will be the basis of any insurance issued.

\_\_\_\_\_  
Proposed Insured

\_\_\_\_\_  
Agent

\_\_\_\_\_  
Date