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Vocational Assessment Form - Disability

THESE BENEFITS ARE PAID UNDER A POLICY UNDERWRITTEN BY LIFE INSURANCE COMPANY OF NORTH AMERICA.

Disability Questionnaire

In order to assist us with the processing of your Disability claim, and/or to assist in your potential to benefit from rehabilitation, please complete this questionnaire in its entirety and return it in the envelope provided.

Name: Social Security #:

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

Two horizontal lines for writing the answer to question 1.

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

Two horizontal lines for writing the answer to question 2.

Education

Table with 5 columns: HIGH SCHOOL (# of years), DIPLOMA or GED, COLLEGE (# of years), DEGREE, MAJOR. Includes checkboxes for diploma and GED.

VOCATIONAL/TECHNICAL TRAINING:

MILITARY TRAINING:

Daily Living Status

Right or Left Hand Dominant: Height: Weight:

Are you able to take care of all your personal care needs (grooming, dressing, etc.)? If not, what areas require assistance?

Please indicate the chores you currently perform on a regular basis: (check all that apply)

- Checkboxes for Cooking, Shopping, Laundry, Cleaning, Child Care, Yard Work, Gardening, and Other (please describe).

Do you read newspapers, magazines, or books? Yes No

Do you go for walks? Yes No

If so, how often and how far do you go?

Please list which activities you currently attend? (school, therapy, or vocational rehabilitation, etc.)

What do you currently do for fun? (knitting, bingo, playing cards, woodworking, mechanics, computers, fishing, etc.)

Work Experience

List all jobs you have had, the most recent first. Attach additional paper if needed.

EMPLOYER:		JOB TITLE:		
ADDRESS:		CITY	STATE	ZIP
DATE STARTED:	DATE LEFT/REASON:		SALARY: \$	

SPECIFIC DUTIES:

EMPLOYER:		JOB TITLE:		
ADDRESS:		CITY	STATE	ZIP
DATE STARTED:	DATE LEFT/REASON:		SALARY: \$	

SPECIFIC DUTIES:

EMPLOYER:		JOB TITLE:		
ADDRESS:		CITY	STATE	ZIP
DATE STARTED:	DATE LEFT/REASON:		SALARY: \$	

SPECIFIC DUTIES:

Vocational Information

BUSINESS SKILLS: Indicate if, how and when you have performed any of the following:

BOOKKEEPING:	SCHEDULING:
INVENTORY CONTROL:	SUPERVISING:
SHIPPING/RECEIVING:	INSTRUCTING:
OTHER:	

CLERICAL SKILLS: Put a check mark next to skills you can perform:

SHORTHAND FILING TYPING
 DATA ENTRY TRANSCRIPTION

OFFICE EQUIPMENT: Put a check mark next to equipment you have operated:

COPY MACHINE WORD PROCESSOR
 FAX MACHINE PERSONAL COMPUTER

LIST SPECIAL LICENSES OR CERTIFICATIONS:

_____ / / () _____
 MEMBER'S SIGNATURE DATE PHONE NUMBER

_____ STATE _____ ZIP CODE _____

