EPIC SPECIALTY BENEFITS

The EPIC Life Insurance Company
1717 W. Broadway | P.O. Box 8430 | Madison, WI 53708-8430
800-520-5750

ACTIVITIES OF DAILY LIVING

Notice to all persons completing this questionnaire: It is fraudulent to fill out this form with information you know to be false or to knowingly omit important facts.

Name (please print):_____ **Customer ID Number:**_____

Address:_____

Telephone number:_____ **E-mail address:**_____

GENERAL INFORMATION

Please describe your ***current*** medical condition and any progress or retrogressing you believe you have made since you stopped working:

List ***all*** the medical problems for which you see a doctor:

List ***all*** medications you are ***currently*** taking along with their dosage and frequency:

Date of last doctor's office visit: _____ Date of next doctor's office visit: _____

Do you live alone? ☐ Yes ☐ No Are you married or have a significant other? ☐ Yes ☐ No

If you are married or have a significant other, does this person work? ☐ Yes ☐ No If yes, what is their occupation:

_____

What is your height? _____ What is your weight? _____ lbs/kgs

EDUCATION AND WORK EXPERIENCE

Please indicate the extent of your formal education (*circle one*)

Grade: 1 2 3 4 5 6 7 8 9 10 11 12 College: 1 2 3 4 Masters Ph.D. Trade School

If your education exceeds 12th grade, please indicate your major: _____

Briefly describe your past work experience for the last 20 years (*begin with your most recent job*).

Job Title / Employer Name	Duties	Dates Worked
(1)		
(2)		
(3)		
(4)		

Did any of the positions listed above require additional training on your part? ☐ Yes ☐ No If yes, please indicate the nature and type of training (on the job, course work, etc.):

What do you perceive to be your current restrictions and limitations?

If retraining were made available to you, what occupation(s) would you be interested in?

PERSONAL CARE

Describe any changes in your sleeping habits since your condition began:

Do you need any assistance in dressing and/or grooming? ☐ Yes ☐ No If you need assistance, describe the help you require ***and*** how frequently:

Do you have problems with your memory? ☐ Yes ☐ No If you have problems with your memory, please describe the problems and how often they occur:

Do you prepare your own meals? ☐ Yes ☐ No If you prepare your own meals, which meals do you prepare? (check all that apply)

☐ Breakfast ☐ Lunch ☐ Dinner If you do not prepare your own meals, who helps you?

Have your eating habits changed since your condition began? ☐ Yes ☐ No

Provide examples of the type(s) of changes in your eating habits:

HOUSEHOLD CARE

Are you responsible for the financial management of your household? ☐ Yes ☐ No If you are responsible for the financial management of your household, explain what you do (for example, write checks, pay mortgage, maintain bank records, make bank deposits, etc.):

If you are not responsible for the financial management of your household, who is?

Do you do housework? ☐ Yes ☐ No If you do housework, check the kinds of household activities you do:

☐ Laundry ☐ Dusting ☐ Vacuuming ☐ Washing Dishes ☐ Household Repair ☐ Car Care ☐ Garden and Lawn Care ☐ Trash ☐ Recycling ☐ Other *Specify:* _____

If you do not do household duties, please indicate who does the household duties for you: _____

How often do you do household activities? ☐ Daily ☐ Twice a week ☐ Weekly ☐ Monthly

Approximate time spent on household activities: Daily? _____ Weekly? ____ Monthly? _____

Do you require breaks? ☐ Yes ☐ No

Describe any changes in your ability to care for your household and any assistance required since your disability began:

Do you drive? ☐ Yes ☐ No

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

Do you take public transportation? ☐ No ☐ Yes Do you need assistance to travel? ☐ Yes ☐ No

If you need assistance to travel, describe why you need assistance, who assists you, and any changes in your travel since your condition began:

Do you shop? ☐ Yes ☐ No

What kinds of shopping do you do? ☐ Food ☐ Clothes ☐ Gifts ☐ Other *Specify*: _____

How often do you shop? ☐ Daily ☐ Twice a week ☐ Weekly ☐ Monthly

Approximate time spent on shopping? Daily? _____ Weekly? _____ Monthly? _____

Do you require assistance when you shop? ☐ Yes ☐ No If you require assistance when you shop, describe the assistance you require:

If you have childcare responsibilities, answer the following questions:

What care are you able to provide for your child/children/grandchildren:
☐ Bathe ☐ Change Clothes ☐ Change Diaper ☐ Feed ☐ Carry ☐ Play Activities ☐ Lift ☐ Read ☐ Other *Specify:* _____

Approximate time spent on childcare activities: Daily? _____ Weekly? _____ Monthly? _____

Do you require assistance to perform any of these childcare activities? ☐ No ☐ Yes If you require assistance to perform childcare activities, describe the assistance you need, who provides assistance, and how frequently do you require this assistance:

INTERESTS AND HOBBIES

Do you read? ☐ Yes ☐ No

If you read, what do you read? ☐ Books ☐ Magazines ☐ Newspapers ☐ Other *Specify:* _____

Approximate time spent on reading: Daily? _____ Weekly? _____ Monthly? _____

Do you watch TV? ☐ Yes ☐ No If you watch TV, how many hours do you watch daily? _____

Do you use a computer? ☐ Yes ☐ No If yes, how often and for what purpose? _____

In what types of hobbies or activities do you participate?

☐ Fishing ☐ Craft ☐ Sewing ☐ Swimming ☐ Bowling ☐ Continuing Education Courses ☐ Movies ☐ Sports ☐ Golfing ☐ Other *Specify:* _____

How often do you engage in these activities/hobbies? ☐ Daily ☐ Twice a Week ☐ Weekly ☐ Monthly

Do you travel in excess of thirty miles from your home? ☐ Yes ☐ No If yes, how do you travel and how frequently do you travel:

SOCIAL CONTACTS

Are you an active member of any club(s) or organization(s)? ☐ Yes ☐ No If you are an active member, describe your responsibilities and activities:

How often do you participate in these activities? ☐ Daily ☐ Twice a Week ☐ Weekly ☐ Monthly

Do you hold any positions in your club(s) or community organization(s)? ☐ Yes ☐ No If you hold any positions, describe them:

Do you do volunteer work? ☐ Yes ☐ No If you do volunteer work, describe your volunteer activities, including the location, duties performed, hours and frequency of participation:

Do you visit with friends or relatives? ☐ Yes ☐ No If yes, how often do you visit? ☐ Daily ☐ Weekly ☐ Weekends ☐ Monthly

Estimate how long these visits last (i.e., number of hours): _____

Has there been any change in your social contacts since your disability began? ☐ Yes ☐ No If there has been any change in your social contacts or you require assistance to maintain these social contacts, describe the change(s) and assistance you require:

OTHER INFORMATION

Have you participated in a rehabilitation or retraining program? ☐ Yes ☐ No If you have participated in a rehabilitation or retraining program, provide the name, address and telephone number of the program:

Do you believe that you will be able to return to work? ☐ Yes ☐ No If you do not believe that you will be able to return to work, describe
the reason(s) supporting your belief:

List all your current sources of income and the amount received from each source:

What is the status of your Social Security disability claim? ☐None ☐Pending ☐Approved* ☐Denied
If denied, please supply a copy of denial letter.

Since ceasing work, have you performed work for any other employer or self employment? ☐ No ☐ Yes
If Yes, please indicate the name and contact information for your employer:

The information I have provided on this form is accurate to the best of my knowledge.
I have received and read the fraud warning statements provided with this form.

Signature_____Date_____

MAIL OR FAX FORM TO:

EPIC Specialty Benefits
Attention: Life & Disability Claims
P.O. Box 8430
Madison, WI 53708-8430
Fax: 608-223-2179
E11869-1502