MATRIX
Absence Management, Inc.

7 Skyline Drive, Suite 275
Hawthorne, NY 10532

Long Term Disability Claim Application

If you have any questions, please call our toll free number: (877) 315-9838.

Other Income Questionnaire

☐ **I certify that I am currently receiving no other income.**

☐ **I certify I have applied for other income as defined below.**

☐ **I certify that I am currently receiving or have received other income as defined below.**

Provide information as to all of the following types and/or sources of other income:

- Salary/Wages from present employer
- Income from self-employment
- Rehabilitation Earnings
- Pension/Retirement (including Canada)
- Part-time Earnings
- Veteran's Benefits
- Unemployment Compensation
- Jones Act or Maritime Doctrine
- Recoveries from Third Party causing disability
- Social Security Disability – Primary
- Social Security Disability – Family
- Social Security Retirement
- Social Security Widow/Widowers Benefit
- State Disability Plans
- Workers' Compensation – Periodic/Lump Sum
- No-Fault Automobile Coverage
- Railroad Retirement
- Private Group Disability benefits

List other Income you are receiving or have received or have applied for:

Source of Income	Effective Date of Benefits	Benefit Amount and Frequency

Signature	Date

REIMBURSEMENT AGREEMENT

If I receive a disability payment greater than that which should have been paid, I understand that Matrix Absence Management, Inc. has the right to recover such overpayment from me, including the right to reduce future disability benefits, if any.

Signature	Date

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

To All Providers of Health Care: You are authorized to provide Matrix Absence Management, Inc. or one of its affiliated companies, and any independent claim administrators and consulting health professionals with whom Matrix has contracted, information concerning health care, advice treatment or supplies, including those related to mental illness and/or AIDS/ARC/HIV, provided to me. This information will be used for the purpose of evaluating and administering my disability claim. This authorization is valid for the term of the coverage of the policy or contract under which a claim has been submitted. I know that I have a right to receive a copy of this authorization upon request and agree that a photographic copy of this authorization is as valid as the original.

Signature	Date