



Group number: \_\_\_\_\_

# Disability Application Form

Instructions: Please complete boxes outlined in **RED**

## A: Personal Information

Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ First Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security Number: \_\_\_\_\_  
Street Address: \_\_\_\_\_ Apt #: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Home Phone Number: \_\_\_\_\_ E-mail Address: \_\_\_\_\_  
Marital Status:   Single       Married       Divorced       Widowed  
Gender:       Male       Female  
Occupation: \_\_\_\_\_ Date of Hire: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Hours: \_\_\_\_\_ Salary: \_\_\_\_\_  
Sub-Group:       Specialty Composites       Waco Boom  
Is the applicant currently a smoker?       Yes       No  
Has the applicant used any tobacco products in the past 12 months?       Yes       No

## B: Acknowledgement of Coverage and Signature

Name Printed: \_\_\_\_\_

Signature: \_\_\_\_\_

Signature Date: \_\_\_\_/\_\_\_\_/\_\_\_\_