Disability Management Services, Inc.

A third party administrator for:

AXA Equitable Life Insurance Company

1350 Main Street, Suite 1600 Springfield, MA 01103-1641 Tel:(413)747-0990 or (800) 299-6921 Fax:(413)747-1545

Continuance of Disability

TO BE COMPLETED BY THE INSURED

1) Insured's Name:	2) Policy Number(s):	3) Claim number:
4) Residence address:	5) Telephone number:	
6) Describe in detail your typical daily activities:		
7) Have you performed any work since the date of your last report? Yes _____ No _____	8) If "No" state when you expect to resume work:	
9) If "Yes", give dates, hours and describe duties performed, along with monthly earnings:		

10) Are you now eligible for, have you applied for, or are you receiving income benefits from:

Social Security(Disability or Retirement Benefits)	Yes _____	No ___	Workers' Compensation	Yes _____	No _____
Unemployment Compensation	Yes _____	No ___	Pension Disability	Yes _____	No _____
Any Other Disability Income Benefit	Yes _____	No ___	State Disability Plan	Yes _____	No _____

11) If "Yes", to any of the items in question #10, please provide details including amounts received, effective dates, and the name of the company, organization, or governmental agency from which benefits are being received:

Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is or may be guilty of a criminal act punishable under law.

Signature:	Date:

Please complete your portion of the form on the reverse side and forward the form to your attending physician.

Authorization For Release Of Information: I hereby authorize the undersigned physician to release any information acquired in the course of my treatment.	Signature:	Date:
	Print Name:	

To be completed by the attending physician

Dear Doctor:
Please answer all applicable questions below regarding the above mentioned patient.
A return envelope has been provided for your convenience.
Thank you for your prompt cooperation so as to avoid delays in handling this patient's claim.

1) Current Diagnosis:		
2) Symptoms observed by physician:		
3) Objective findings: (include date and results of most recent diagnostic tests)		
4) Dates of treatment within the past three months:		
5) Briefly describe the current plan of treatment:		
6) Is the current plan of treatment expected to improve the patient's physical or cognitive function? If so, within what time frame?		
7) Please identify the patient's insurance providers for: Medical Insurance:_____ Disability Insurance:_____ Workers' Compensation:_____ Automobile Insurance:_____		
8) Is the patient competent to manage his or her property unassisted, and to understand the nature and consequence of his or her actions, including the ability to endorse checks and direct use of the proceeds? Yes _____ No _____		
9) Additional comments or progress:		
10) Name of physician:	11) Degree(s):	12) Tax Identification Number:
13) Address:	14) Telephone number:	
15) Signature:		16) Date: