Northwestern Mutual®
P. O. Box 2918
Milwaukee, Wisconsin 53201-2918

DISABILITY INCOME DEPARTMENT
DISABILITY BENEFITS DIVISION
1-800-748-9493, ext. 6612016

REQUEST FOR CONTINUANCE OF DISABILITY BENEFITS

INSURED	POLICY NUMBER	CLAIM NUMBER

Please return form by _____. *If you anticipate a delay, contact our office at the phone number above.*

Information on this form is required to determine whether you qualify for continuance of disability benefits. In order to avoid unnecessary delays in the processing of additional benefits that may be due, all questions must be thoroughly answered. ***This form should be completed in black ink ONLY by the Insured or by his or her representative if the Insured is incapable. Please answer all questions.***

Has there been a change in your home address or telephone number since the last request for benefits? Please check and complete the items that apply. ☐ Address Unchanged ☐ Phone Number Unchanged

NEW ADDRESS	
NEW CITY, STATE, ZIP CODE	NEW PHONE NUMBER *(include area code)* ( )

1. Since the last request for benefits, have you performed **any work of any kind AT YOUR PRIOR OCCUPATION *or* AT ANY OTHER OCCUPATION** whether or not you received any income?

☐ **Yes** **A.** As of what date?_____ / _____ / _____ (MM/DD/YYYY)

B. Please provide the following information regarding your employer(s).
If unchanged since last request for benefits, please check this box → ☐

Business/Employer Name	Address/City/State/Zip Code
Phone Number ( )	

C. Do you have any ownership in this business? ☐No ☐Yes *If yes, ownership % is* _____%.

D. Number of hours worked per week: _____

List the duties you performed and the percent of time spent at each duty.

Principal Duties Performed Since the Last Request For Benefits	% of Time at Duty
1.	%
2.	%
3.	%
4.	%

= 100%

E. During each of the first six months in which a partial benefit is available, the policyowner may choose to receive **either** 50% of the benefit *(see exclusions below)* **or** a calculated benefit. If you are within the first six months of partial disability, please choose one of the following:

☐ **50%** of the full monthly benefit

OR

☐ **CALCULATED** benefit based on the actual loss of earned income

- *Not available after the first six months that a partial disability benefit is payable (for disability policies that contain the 50% choice)*
- *Not available on Loss of Earnings contract - a calculated benefit is required*

☐ **No** **A.** When do you think you will be able to return to work? _____ / _____ / _____ (MM/DD/YYYY)

B. Have you gone to your place of business or employment for any reason? ☐Yes ☐No
If yes, please complete the following:

1. How often do you go to your place of business/employment? _____
2. What do you do while you are there? _____
3. How much time do you spend there per visit? _____

THE HOME OFFICE WILL ACCEPT A FAX TRANSMISSION OF THIS ORIGINAL, SIGNED DOCUMENT
FAX Number: (414) 625-1526

2. Please describe the current limitations or restrictions that prevent you from performing on a full-or part-time basis some or all of the principal duties of the occupation which you had at the start of your disability or from working as many hours as you did at the start of your disability.

3. What are your daily activities outside of work?

4. Please explain any change in your medical condition or medical treatment since your last request for benefits.

5. Please provide the names, complete addresses and phone numbers of any new pharmacies and all physicians and/or treatment providers you have seen for **any reason** since your last request for benefits.

Medical Provider/Pharmacy/Mail Order	Address/Phone Number
	( ) -
	( ) -
	( ) -

6. Have you been hospitalized for **any reason** since your last request for benefits? ☐ Yes ☐ No
If yes, please provide the hospital/city/state, date of admission and reason for treatment.

Hospital/City/State	Date of Admission	Reason for Treatment
	___ / ___ / ___	

7. Have you applied for Social Security ☐ **Disability** ☐ **Retirement** benefits? ☐ Yes ☐ No
If yes, as of what date? _____ / _____ / _____ (MM/DD/YYYY)

8. Are you receiving Social Security ☐ **Disability** ☐ **Retirement** benefits? ☐ Yes ☐ No
If yes, for whom? ☐ Worker and/or ☐ Dependent *Effective date:* _____ / _____ / _____ (MM/DD/YYYY)

9. Are you (or the business in which you have ownership) currently involved in or contemplating filing for bankruptcy?
☐ Yes ☐ No

10. Since your last request for benefits, has there been a change in the status of any professional license you hold?
☐ Yes ☐ No *If yes, please explain:* _____

11. **Please list all of your disability insurance benefits from other sources** *(Please include other disability income, disability overhead expense, no fault, life insurance waiver of premium, worker's compensation, state disability benefits, credit disability coverage, mortgage disability coverage, etc.)* ☐ **Check if none.**

Source Name	Type of Benefit	Amount	Policy Number	Receiving Benefits
				☐ Yes ☐ No
				☐ Yes ☐ No

By signing below, I agree to the statements contained in the Authorization(s) and I declare that all of the answers and amounts reflected above and on any attached financial or tax statements are complete and true to the best of my knowledge and belief. I understand that the Company reserves the right to require further proof. Proof for the purpose of this policy includes (but is not limited to) medical documentation, earned income and expenses, confirmation of occupation/job duties and full details of other insurance.

Some states require us to inform you that any person who knowingly files a statement of claim containing false or misleading information is subject to criminal and civil penalties, depending upon the state. Such actions may be deemed a felony and substantial fines may be imposed. In New York, the fine shall not exceed $5,000 and the stated value of the claim for each such violation.

_____ _____ OR _____
DATE (MM/DD/YYYY) SIGNATURE OF INSURED INSURED'S REPRESENTATIVE

If representative, print name and relationship to Insured: _____