Prudential

Activities of Daily Living Questionnaire

Claim Number _____

1 Claimant Information

Name _____

Home/Mobile Phone _____ / _____

E-mail _____

2 Medical Information

Note: If you require more space for your answers, please document on additional paper.

What is your height? _____

What is your weight? _____ lbs.

Which is your dominant hand? ☐ Right ☐ Left

List all the medical conditions that prevent you from returning to work:

_____

_____

_____

_____

_____

What part of your job can you not do and why?

_____

_____

_____

_____

_____

Do you have any other medical conditions that **do not** prevent you from working? ☐ Yes ☐ No

If yes, please note below these conditions:

_____

_____

_____

_____

_____

Provide the names, addresses and telephone numbers of all physicians who have treated you **within the past 12 months** for the above noted conditions **that prevent you from returning to work**:

Doctor's full name:	Last office visit date:
Specialty:	Next office visit date:
Address:	Telephone:
	Fax
Doctor's full name:	Last office visit date:
Specialty:	Next office visit date:
Address:	Telephone:
	Fax
Doctor's full name:	Last office visit date:
Specialty:	Next office visit date:
Address:	Telephone:
	Fax

2 Medical Information (Cont'd)

Note: If you require more space for your answers, please document on additional paper.

Which physician is certifying your current disability status? :

Please list all medication(s) that you are currently taking:

Medication name	Prescribing doctor	Date prescribed	Dosage & frequency taken

3 Personal Care

What time do you normally get up? _____ What time do you normally go to bed? _____

Do you have any trouble sleeping? ☐ Yes ☐ No Do you take naps? ☐ Yes ☐ No

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

Do you need any assistance in dressing and/or grooming? ☐ Yes ☐ No

If yes, who provides you with assistance?

Do you require the use of an assistive device such as a cane/a walker/a wheelchair/a scooter to help with walking or ambulation? ☐ Yes ☐ No

If yes, please describe below the help or assistive device(s) that you utilize:

Do you have any problems with your memory? ☐ Yes ☐ No

If yes, please describe below the problems **and** how often they occur:

Do you prepare your own meals? ☐ Yes ☐ No

If yes, which meals do you prepare? ☐ Breakfast ☐ Lunch ☐ Dinner

If you do not prepare your own meals, who helps you?

4 Transportation

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

If you do not drive, has your doctor restricted you from driving? ☐ Yes ☐ No

If you do drive, how many times per week do you drive? _____

What is the distance you can travel as a driver? _____ miles

What is the distance you can travel as a passenger? _____ miles

Prior to your disability absence:

What was the distance you could travel as a driver? _____ miles

What was the distance you could travel as a passenger? _____ miles

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

If you do require assistance with travel, please describe below why you need assistance; who assists you; and, any changes that have impacted your ability to travel since your condition began:

_____

_____

_____

_____

5 Household Care

Do you live alone? ☐ Yes ☐ No

If no, please check who lives with you: ☐ Spouse ☐ Partner ☐ Relative ☐ Friend ☐ Roommate

If you are married/have a partner, what is your spouse or partner's name? _____

What is your spouse or partner's date of birth? _____

Does your spouse/partner work? ☐ Yes ☐ No What is their occupation? _____

Do you have dependent children? ☐ Yes ☐ No

If yes, please provide the following information:

Dependent name:	Date of birth:
Dependent name:	Date of birth:
Dependent name:	Date of birth:
Dependent name:	Date of birth:

Are you responsible for the financial management of your household? ☐ Yes ☐ No

If you are responsible for the financial management of your household, explain below what you do (for example, write checks/pay mortgage/maintain financial records/make bank deposits/etc.):

_____

_____

_____

_____

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

Do you have a power of attorney? ☐ Yes ☐ No

If yes, please confirm below the name of the individual and relationship. Be sure to attach a copy of the power of attorney record (if you haven't already) to this document for file records.

Name: _____ Relationship: _____

Do you perform any type of housework? ☐ Yes ☐ No

If you perform housework, check the kinds of household activities you do:

☐ Car Care ☐ House Painting ☐ Lawn Care ☐ Trash
☐ Dusting ☐ Household Repair ☐ Mopping ☐ Vacuuming
☐ Gardening ☐ Laundry ☐ Recycling ☐ Washing Dishes
☐ Other Specify _____

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5 Household Care (Cont'd)

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

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

If you **do not** perform the above mentioned household activities, who is responsible for assisting you with these duties?

_____

Please explain below specifically what household activities you **can not** do and why you can not do them:

_____

_____

_____

_____

Please check which item best describes your home situation: ☐ One level ☐ Bi-level ☐ Multi-level ☐ Apartment with elevator ☐ Apartment without elevator ☐ Other Please describe _____

If you have child care responsibilities, as a parent, grandparent or baby-sitter, check any of these roles you provide, and answer the following questions on what child care activities you provide:

☐ Bathing ☐ Feeding ☐ Reading ☐ Transportation to School/Sporting Events
☐ Carrying ☐ Infants ☐ School Age ☐ Volunteer for School
☐ Changing Clothes ☐ Lifting ☐ Toddlers ☐ Volunteer for Sports Leagues
☐ Changing Diapers ☐ Play Activities
☐ Other Specify _____

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

Do you require assistance to perform any of these childcare activities? ☐ Yes ☐ No

If you require assistance to perform childcare activities, please describe below the assistance you need; who provides this assistance; and how frequently you require this assistance:

_____

_____

_____

_____

6 Interests and Hobbies

Do you shop? ☐ Yes ☐ No

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

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

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

Do you require an assistance when you shop? ☐ Yes ☐ No

If you require an assistance when you shop, please describe below the assistance that you require:

_____

_____

Do you read? ☐ Yes ☐ No

If you read, what do you read? ☐ Books/Novels ☐ Magazines ☐ Newspapers ☐ Other Specify _____

Approximate time spent reading: _____ Daily _____ Weekly _____ Monthly

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

What types of hobbies or activities do you participate in? (please check all that apply)

☐ Aerobics ☐ Crafts ☐ Gym ☐ Movies ☐ Swimming
☐ Bicycling ☐ Fishing ☐ Hunting ☐ Running ☐ Tennis
☐ Bowling ☐ Golf ☐ Knitting ☐ Sewing
☐ Other Sports Specify _____

6 Interests and Hobbies (Cont'd)

Do you walk for exercise? ☐ Yes ☐ No

Approximate time spent walking: _____ Daily _____ Weekly _____ Monthly

How far do you walk? _____ Does someone walk with you? ☐ Yes ☐ No

If yes, who? _____

Do you own a computer? ☐ Yes ☐ No

What do you use your computer for? _____

Other hobbies/interests not mentioned, please specify:

_____

_____

How often do you spend time on any given activity or hobby? ____ Daily ____ Twice a week ____ Weekly ____ Weekends ____ Monthly

What is the amount of time you spend on each activity/hobby mentioned? _____

7 Social Contacts

Are you an active member of any club(s) or community organization(s)? ☐ Yes ☐ No

If yes, how often do you participate in these activities? _____

Please provide below the names, addresses and phone numbers for these organizations:

_____

_____

_____

_____

Do you perform any volunteer work? ☐ Yes ☐ No

If yes, please provide below the name of the volunteer program, describe your volunteer activities, frequency of participation, and scheduled hours of participation:

_____

_____

_____

_____

Do you visit with friends or relatives? ☐ Yes ☐ No

How often do you visit? ____ Daily ____ Twice a week ____ Weekly ____ Weekends ____ Monthly

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

8 Ongoing Education/ Training

Check your highest level of **formal** education completed:

Elementary school: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8

Secondary school: ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ GED

College/University: ☐ 13 ☐ 14 ☐ 15 ☐ 16 Name of College/University: _____

Post Graduate: ☐ Name of College/University: _____

Are you presently attending college? ☐ Yes ☐ No For a degree? ☐ Yes ☐ No Type: _____

Name of college: _____

Address: _____

Number of years completed: _____ Anticipated graduation date: _____

Area(s) of concentration: _____

Are you presently pursuing any vocational training? (i.e. formal training obtained through business, vocational, or other training institutions.)

☐ Yes ☐ No Where? _____

When? _____ Length of training? _____

8 Ongoing Education/ Training (Cont'd)

Certificates or licenses obtained: _____

Have you, or, are you presently pursuing any other training or adult classes in computers, personal finance, real estate, crafts, art, etc.?

☐ Yes ☐ No

If yes, please note below the type of classes, facility name and location, frequency of classes, duration, and dates of class(es):

_____

_____

_____

_____

9 Rehabilitation Efforts

Have you participated in a rehabilitation or retraining program? ☐ Yes ☐ No

If you have participated in a rehabilitation or retraining program, provide below the name of the program, along with the address and telephone number of the provider, counselor name, and the dates of the program:

_____

_____

_____

_____

Are you currently working? ☐ Yes ☐ No If yes, how many hours per week do you work? _____

Please provide below the name and address of the employer, position held, and current salary:

_____

_____

_____

_____

Have you attempted working since this claim began? ☐ Yes ☐ No

If yes, please provide below the name and address of the employer, position held, salary, and the reason you stopped working. Additionally, please confirm the dates you worked.

_____

_____

_____

_____

Are you self-employed? ☐ Yes ☐ No

If yes, please describe below:

_____

_____

_____

_____

If you are not presently working, 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 below the reason(s) supporting your belief:

_____

_____

_____

_____

_____

_____

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10 Other Income

Please report all the current sources of income you receive and the amount received from each source:

Type of Income	Please check	Effective Date	Amount of Benefit
Social Security Disability - Primary*	☐ Yes ☐ No		
Social Security Disability- Family*	☐ Yes ☐ No		
Social Security Retirement*	☐ Yes ☐ No		
Social Security Survivor*	☐ Yes ☐ No		
Pension and/or Retirement Benefits*	☐ Yes ☐ No		
Workers' Compensation Benefits*	☐ Yes ☐ No		
Individual or group disability benefits secondary to this claim coverage	☐ Yes ☐ No		
Any other type of government benefits*	☐ Yes ☐ No		
Other	☐ Yes ☐ No		

***If not previously provided**, attach a copy of any award/denial notice you have received.

11 Social Security Application Information

Please provide the status of your Social Security Disability claim. (check all that apply)

☐ No application filed ☐ Approved Date approved _____

☐ Pending Level (please circle level) Initial, Reconsideration, Administrative Law Judge, Date: _____

☐ Denied Level (please circle level) Initial, Reconsideration, Administrative Law Judge, Date: _____

Appeal Filed (on most recent denial): ☐ Yes Date filed: _____ ☐ No

(Please provide copies of correspondence from Social Security regarding status of application.)

Do you have an attorney or an agency representing you in your claim for Social Security Disability Benefits, or for any other type of income benefit?
☐ Yes ☐ No

If you have an attorney or agency representing you, please provide name, address and telephone number:

_____

_____

_____

_____

12 Claimant Signature

Notice to all persons completing this questionnaire: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. It is fraudulent to fill out this form with information you know to be false or to knowingly omit important facts. The information I have provided on this form is accurate to the best of my knowledge.

X _____
Claimant Signature

☐☐ ☐☐ ☐☐☐☐
Date Signed (MM DD YYYY)

If someone other than the insured has completed form, please provide the name and telephone number below.

_____ _____
Printed name Telephone number

X _____
Signature

☐☐ ☐☐ ☐☐☐☐
Date Signed (MM DD YYYY)