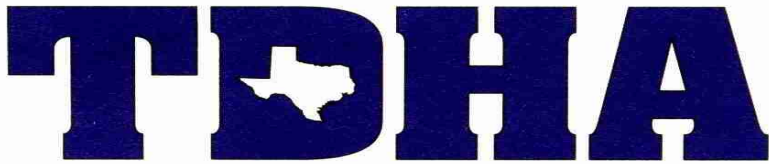


Disability Questionnaire



Texas Dental Hygienists' Association

Name: _____	Date: _____
Phone: _____	Fax #: _____
E-Mail: _____	
Date of Birth: _____	Use tobacco?: _____
Occupation: DENTAL HYGEINIST	or list other Occupation _____

Are you Actively at work? _____ Yes _____ No

Do you work Full-Time? (30 hours minimum) _____ Yes _____ No

Date of Full-Time Employment _____

Do you have coverage now? _____

 Monthly benefit? _____

 Group or individual policy? _____

 Paid personally or by employer? _____

 Through which insurance company? _____

What is **net** monthly income? _____

What is your **net** yearly income? _____

Any significant medical history? _____

Medications taken in the past 3 years? _____

Fax to 817-569-8304
Questions? Call 877-497-3757
or info@TDHAperks.com