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Augusta, ME 04332-0349
Telephone: (207) 512-3100
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ADDENDUM TO APPLICATION FOR DISABILITY RETIREMENT BENEFITS

Member Name: ______ Prefix ______ First ______ MI ______ Last ______ Suffix

Date: ______ Last Four Digits of Your Social Security Number: ______

About Your Medical Condition

Condition: ______

1. When did this condition first bother you? ______
2. What symptoms does this condition cause?
3. How do these symptoms interfere with your life?
4. What limitations does this condition and its symptoms cause in your ability to function?
5. How are you presently being treated for this condition, including taking any medications?

   By whom? ______ How often? ______
6. Is this treatment helping? ❑ Yes ❑ No Explain:
7. What restrictions has your healthcare provider put on your activities, as a result of this condition?

   Healthcare Provider's Name: ______

   When were restrictions applied? ______

   Do you comply? ______
8. Have you ever sought a second opinion about this diagnosis or treatment? ❑ Yes ❑ No

   If "Yes," give healthcare provider's name and results.
9. Have you tried other treatments/medications/steps in the past? ❑ Yes ❑ No If "Yes," with what result?
10. Have you declined to try any recommendation of healthcare providers for managing or minimizing the effects of this condition? ❑ Yes ❑ No If "Yes," what has been declined and why?