Seneca Nation Disability Services

Request for Policy Waiver

Date Complete: _____
Claim #: _____
Hearing Date:_____
Determination:_____

Applicant Information

Name: _____ SSN:_____
Last *First* *M.I.*

Phone: _____ DOB: _____ Enrollment #: _____

Physical Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Mailing Address: _____
P.O. Box *Apartment/Unit #*

_____
City *State* *ZIP Code*

Email Address: _____

Are you currently employed? YES ☐ NO ☐ If yes, where: _____

Full-Time:____ Part-Time:____ Monthly Income: $_____

Are you currently a student? YES ☐ NO ☐ If yes, where: _____

Full-Time:____ Part-Time:____

Household Size: _____ Adults:_____ Children:_____

Claim Information

Which of the following situation applies to your request for a waiver?

Did you submit an **initial claim** for a long-term disability benefit? YES ☐ NO ☐ If yes, benefit type:_____

Was your initial claim for a long-term disability benefit **denied**? YES ☐ NO ☐ Did you appeal the determination? YES ☐ NO ☐

Initial Claim Date:_____ Denial Date:_____ Appeal Date:_____

Were your disability benefits terminated after a **review** of your case? YES ☐ NO ☐ Did you appeal the determination? YES ☐ NO ☐

Denial Date:_____ Appeal Date:_____

Waiver Justification

Please fill out the following as clearly and completely as possible. The review panel will use this to make a determination to approve or deny your request for a waiver. You may use additional paper if necessary. Leaving blank will result in a denial.

Please explain reason, facts and circumstances for your request. Be detailed and provide dates and timelines where applicable.	
Why do you feel these facts and circumstances are unique and require a waiver?	
Please provide any additional information you believe is pertinent to your request.	

Disclaimer and Signature

I certify that my answers are true and complete to the best of my knowledge and believe my circumstances justify a program policy waiver to be eligible to receive the Seneca Nation Disability Payment. I understand it is my responsibility to submit any and all documentation required before a review of my Request for a Waiver can be considered. I understand that I will not be allowed to attend or testify at the review hearing and the review panel will base their determination solely from the documentation and explanation I have provided. I will be notified in writing of their decision within 10 days after the scheduled review hearing. I understand that false or misleading information in my request will result in a denial.

Signature: _____ Date: _____

Documentation Required to Submit a Request for a Waiver:

__Photo Identification	__Social Security Card	__Enrollment Verification
__Proof of Residence	__Proof of Filed Claim	__Denial Letter(s)
__Verification of Disability Form	__Proof of Filed Appeal	__Other Supporting Docs