

Preparing for Your Long-Term Disability Claim When You Live With Pain

By Riemer Hess LLC for the U.S. Pain Foundation

Introduction

This educational resource was prepared by **Riemer Hess LLC**, a national law firm headquartered in New York City, in collaboration with the **U.S. Pain Foundation**. It is intended to help individuals living with chronic pain better understand how long-term disability (LTD) claims are commonly evaluated and to provide general context around employment considerations, medical documentation, and insurer communications.

Living with chronic pain often requires navigating complex medical care while continuing to work for as long as possible. When work becomes unsustainable, the long-term disability process can feel unfamiliar and overwhelming—particularly because pain conditions are frequently misunderstood or oversimplified in insurance reviews. This resource is designed to help orient readers to that process and highlight common issues that arise in pain-related disability claims.

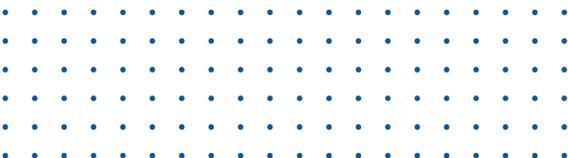
The information provided here is **for general educational purposes only**. It does not constitute legal advice and is not a substitute for guidance tailored to an individual's specific circumstances or insurance policy. Reading this resource does not create an attorney–client relationship.

Every disability claim is unique. This material is intended to support informed decision-making by explaining general concepts, common insurer practices, and areas where misunderstandings often occur. It is not intended to instruct readers on how to pursue a specific claim or to predict outcomes.



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I. Preparing on the Employment Side

Employment circumstances often intersect with long-term disability claims, particularly for individuals living with chronic pain who may continue working while symptoms worsen over time. This section provides **high-level context** about common employment-related issues that can affect how a disability claim is later evaluated. It is intended to orient readers, not to address every possible scenario.

A. Understanding Disability Coverage at a High Level

Long-term disability claims are evaluated under the specific terms of the applicable insurance policy. These terms vary widely and can significantly affect how pain-related claims are reviewed.

Disability policies generally define disability as one of the following:

- **Own occupation** – inability to perform one’s specific occupation
- **Any occupation** – inability to perform any occupation the insurer considers reasonable
- **Hybrid definitions** – own occupation for a period, followed by any occupation

Chronic pain often interferes with **consistency, stamina, and reliability**, which can be especially relevant under these definitions, even when some tasks remain physically possible.

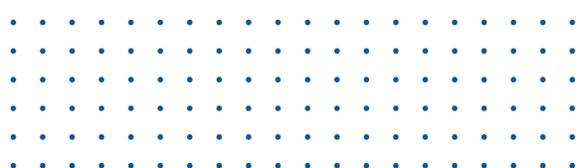
Many policies also contain limitations that may be applied more frequently in pain-related claims, including provisions addressing self-reported symptoms, mental health conditions, or pre-existing conditions. These provisions do not automatically disqualify a claim, but they often shape the level of scrutiny and the type of documentation insurers expect.

B. Communication with Employers

Workplace communication often feels routine or supportive, but employment-related information is frequently reviewed during a disability claim.

Employers and insurers may exchange:

- Human Resources notes
- Performance evaluations
- Attendance records
- Summaries of conversations
- Descriptions of why work changed or ended
- Accommodation requests



As symptoms worsen or work becomes harder to sustain, employer records may later influence how an insurer understands why work ended and whether limitations were present before separation. This is particularly relevant for chronic pain conditions, where individuals often work through symptoms for extended periods before reaching a breaking point.

C. When Continued Work Becomes Unsustainable

For many people with chronic pain, work does not end abruptly. Instead, there may be a gradual period marked by declining stamina, increased flares, more frequent absences, or difficulty maintaining pace and focus.

In some situations, continuing to push through severe pain can:

- Worsen symptoms
- Create records suggesting performance issues rather than medical limitation
- Obscure the connection between health and work capacity

If severance or a separation agreement is offered, it should be reviewed carefully before signing. These agreements often contain language defining the reason for separation or addressing compensation in ways that may later affect how a disability claim is evaluated.

How the reason for separation is documented—across employment records, medical records, and the disability claim—often becomes an important point of review.

D. Transition Work After Leaving Employment

After leaving work, individuals may feel pressure to assist with transition tasks, such as handing over files or answering questions. For people with chronic pain, this often reflects responsibility rather than sustainable capacity.

From a disability perspective, even limited post-separation work can create confusion about when disability began. Insurers frequently review:

- The last day worked
- Whether any work continued afterward
- What that work involved

If transition assistance occurs, limiting it in **time and scope** helps avoid misinterpretation. Brief, administrative assistance is less likely to be misunderstood than continued substantive work.



II. Medical Positioning for a Strong LTD Claim

A. Symptoms, Function, and Limitations

For individuals living with chronic pain, medical records often fail to capture the full impact of the condition. Pain can be persistent, disruptive, and exhausting, yet still difficult to measure during brief office visits or standard testing. Because disability insurers rely heavily on medical documentation, **the way that symptoms and functional limitations are recorded matters as much as the diagnosis itself.**

This section focuses on how pain-related symptoms and limitations are typically evaluated and why clarity around function is critical.

1. Consistency Over Time Matters

Insurers review medical records longitudinally. They look for whether symptoms appear:

- Regularly
- Over an extended period
- Across multiple providers and visits

For chronic pain conditions, records are stronger when they consistently reflect:

- Reports of ongoing pain, not just acute flares
- Persistence of symptoms despite treatment
- An unchanged or worsening functional picture over time

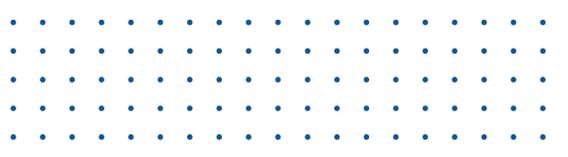
When pain appears only sporadically in records, insurers may assume improvement or resolution, even when that assumption is incorrect.

2. Function Is Often More Important Than Diagnosis

Long-term disability determinations are usually less focused on what condition someone has and more focused on **what that condition prevents them from doing on a sustained basis.**

For chronic pain, functional limitations may include:

- Inability to sit, stand, or walk for prolonged periods
- Need to change positions frequently
- Difficulty performing repetitive movements
- Reduced tolerance for sustained activity
- Fatigue that limits endurance across a full day or week



- Cognitive impacts related to pain, poor sleep, or medication side effects

Medical records are most helpful when they connect pain to **specific functional consequences**, rather than listing pain without context.

3. Limitations Are About Capacity, Not Effort

Pain rarely eliminates all ability. More often, it limits:

- How long activities can be performed
- How often they can be repeated
- How consistently they can be sustained

Insurers sometimes assume that if an activity can be done briefly, it can be done consistently. Clear documentation helps correct this misunderstanding by distinguishing between:

- Isolated or short-term ability, and
- Reliable, sustained work capacity

Limitations may involve:

- Needing frequent breaks
- Experiencing symptom flares after activity
- Requiring extended recovery time
- Reduced pace or productivity

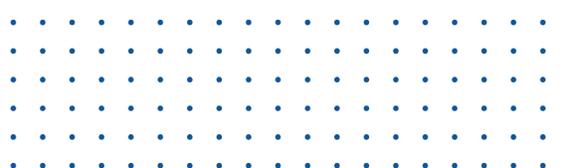
These factors are central to understanding why full-time work becomes unrealistic, even when some tasks remain possible.

4. Frequency, Duration, and Recovery Time Are Critical

Pain-related limitations often involve patterns that are easy to overlook unless they are explicitly documented. These include:

- How often symptoms occur
- How long they last
- What triggers worsened symptoms/pain
- How long recovery takes after activity

Recovery time is particularly important. A person may appear capable during a brief examination but still be unable to meet the demands of a full workday or workweek, because activity on one day worsens functioning on the next.



5. Variability Does Not Undermine Disability

Chronic pain is rarely constant. Many individuals experience:

- Better and worse days
- Short windows of tolerable functioning
- Unpredictable flares triggered by activity or stress

Insurers sometimes misinterpret variability as inconsistency or improvement. Clear documentation should explain that:

- Intermittent functioning does not equal sustained capacity
- Periods of relative relief are often followed by flares
- Symptom patterns are unpredictable and difficult to control

When variability is explained, it supports—rather than undermines—the reality of chronic pain.

6. Patient Experience Should Be Reflected in the Record

Clinical notes often focus on exam findings and treatment plans. While those are important, disability reviews also rely on the patient’s reported experience between visits.

Records are stronger when they reflect:

- How pain affects daily activities
- What happens after exertion
- Whether symptoms interfere with sleep, concentration, or pace
- Why sustained work has become difficult or impossible

This is not exaggeration. It is context. Without it, insurers may assume normal functioning between appointments.

B. Proactive Conversations with Treating Physicians

For many people with chronic pain, conversations with treating physicians focus, understandably, on symptom relief and treatment options. Disability, however, introduces a different lens—one that physicians may not automatically apply unless it is discussed directly.

Having proactive, thoughtful conversations with providers can help ensure the medical record reflects the full reality of living with chronic pain.

1. Treating Physicians May Not Realize What Insurers Look For

Physicians are trained to diagnose and treat—not to document work capacity. As a result:



- Notes may focus on treatment response rather than function
- Improvements may be documented without context
- Ongoing limitations may go unrecorded

Insurers later rely on these same notes when deciding whether someone can work.

2. Discuss Function, Not Just Pain Levels

Pain intensity is important, but insurers are often more focused on **functional impact**. It can be helpful to talk with providers about:

- Ability to sit, stand, or walk over time
- Endurance across a full day
- Recovery time after activity
- Impact of pain on concentration and pace
- How symptoms fluctuate over days or weeks

These conversations help providers document what pain actually prevents.

3. Begin 'Planting the Seeds' Early

Many people with chronic pain reach a tipping point gradually. Early documentation that reflects:

- Increasing difficulty sustaining work
- Worsening flares or reduced recovery
- Declining tolerance for normal work demands

can help explain why work eventually becomes impossible, even if employment continues for a period.

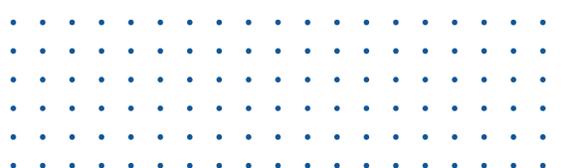
This context matters later, when insurers ask why someone worked as long as they did.

4. Align Medical Records With Real-World Experience

Medical records are most helpful when they reflect:

- What the patient is actually experiencing between visits
- What happens after activity, not just during it
- Why continued work is becoming unsustainable

Patients do not need to exaggerate or dramatize symptoms. Accuracy and completeness are enough.



5. These Conversations Are About Clarity, Not Advocacy

Asking providers to document functional impact is not asking them to “take a side.” It is asking them to record information that is already true but often left out.

Clear documentation helps prevent misinterpretation and reduces the risk that others will draw incorrect conclusions from silence or shorthand.

C. Establishing a Baseline When Disability Follows Treatment

For many chronic pain conditions, disability does not begin at the moment of diagnosis. People often continue working while trying medications, procedures, or therapy—sometimes for months or years—before reaching a point where work is no longer sustainable. When disability follows treatment rather than precedes it, **establishing a clear baseline becomes especially important.**

1. What a Baseline Means

A baseline describes **functional capacity at a specific point in time**, typically before a change in treatment or before symptoms worsened. It helps show:

- What activities were previously possible
- How much endurance existed at that stage
- How function changed over time

A baseline does not imply stability or wellness. It provides context for decline.

2. Why a Baseline Matters in Pain Claims

Insurers often assume that treatment leads to improvement. When work stops after treatment begins, insurers may question why employment ended if care was ongoing.

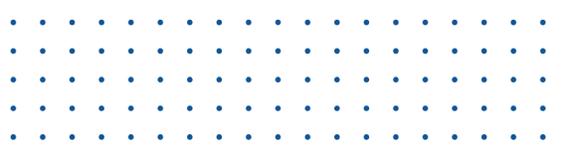
Baseline documentation helps explain that:

- Treatment did not restore sustainable function
- Symptoms worsened or new limitations emerged
- Continued work required increasing effort or recovery time
- Disability developed despite active treatment

This context is particularly important for chronic pain conditions, where progression is often gradual rather than sudden.

Example

An individual living with chronic spinal pain continues working while beginning physical therapy and medication adjustments. Initially, they can manage shortened workdays with recovery time at night. Over time, therapy triggers increased flares, medication causes cognitive side effects, and recovery



extends into the following day. Although treatment continues, endurance declines and full-time work becomes impossible.

Documenting this shift—from earlier function to later limitation—helps explain why disability occurred when it did.

D. Building Objective Evidence (Critical for LTD Claims)

People living with chronic pain often hear that their condition is “subjective.” That label can feel dismissive, especially when pain is severe, persistent, and life-altering. In the disability context, however, insurers use the term “objective” in a very specific way—meaning not that pain must be proven, but rather that it must be **supported where possible**.

Understanding how objective evidence is used can help prevent misunderstandings.

1. What Insurers Mean by “Objective Evidence”

In disability claims, objective evidence generally refers to:

- Diagnostic test results
- Clinical exam findings
- Measurable functional limitations
- Observations documented by medical professionals

Objective evidence does **not** mean that pain must be visible on imaging or reduced to a single test result. Instead, it means there is **something in the record beyond self-report alone** that supports the presence and impact of the condition.

2. Why Objective Evidence Is Especially Important for Pain Claims

Many LTD policies contain provisions that:

- Limit benefits for “self-reported” or “subjective” conditions
- Scrutinize pain claims more aggressively
- Require additional support when symptoms fluctuate

For these reasons, insurers often give more weight to pain claims that are supported by:

- Imaging
- Exam findings
- Functional testing
- Specialist evaluations



This does not mean pain without objective findings is not real. It means insurers are more likely to challenge claims when objective support is limited.

3. Types of Objective Evidence That May Support Pain Claims

Objective evidence varies depending on the underlying condition. Examples include:

Musculoskeletal and Spine-Related Pain

- X-rays, CT scans, or MRIs
- Evidence of disc disease, stenosis, arthritis, or structural changes
- Documented range-of-motion limitations
- Abnormal gait or posture noted on exam

Neuropathic or Nerve-Related Pain

- EMG and nerve conduction studies
- Neurological exam abnormalities
- Sensory deficits or weakness

Rheumatologic or Inflammatory Pain

- Elevated inflammatory markers (e.g., ESR, CRP)
- Autoimmune panels
- Imaging showing joint inflammation or damage

Functional Evidence

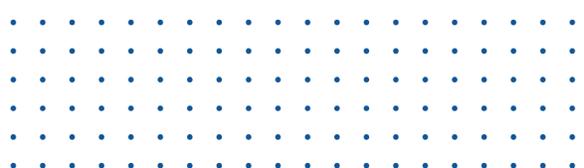
- Functional Capacity Evaluations (FCEs)
- Documented inability to tolerate sustained activity
- Reproducible pain behaviors during testing

Not every test is appropriate for every person. Relevance matters more than volume.

4. Objective Evidence Can Also Document What Treatment Has Not Fixed

Objective findings can help show that:

- Structural issues persist despite treatment
- Functional limitations remain despite therapy
- Pain is not resolving with standard care



This is important for chronic pain claims, where insurers sometimes expect ongoing improvement that is not medically realistic.

5. Objective Evidence Works Best When Paired With Clinical Context

Test results alone rarely tell the full story. They are most persuasive when paired with:

- Consistent symptom reporting
- Exam findings over time
- Functional limitations tied to real-world activity
- Provider explanations of why findings are disabling in practice

A “mild” imaging result can still support disability when it aligns with clinical findings and functional loss.

6. Objective Evidence Is a Tool — Not a Verdict

It is important to emphasize that:

- Lack of a single definitive test does not invalidate pain
- Many pain conditions remain difficult to quantify
- Disability decisions should be based on the total picture

Objective evidence strengthens credibility, but it does not replace lived experience. The strongest records reflect **both**.

E. Second Opinions & Independent Medical Evaluations (IMEs)

For individuals living with chronic pain, treating providers often understand the condition well but may document briefly or conservatively. In some situations, obtaining an additional medical opinion can help clarify functional impact and long-term limitations.

Second opinions and independent evaluations are not about replacing existing care. They are about strengthening the overall medical picture when documentation gaps exist.

1. When a Second Opinion May Be Helpful

Additional medical input may be useful when:

- Symptoms are complex or involve multiple systems
- Functional limitations are significant but under-documented
- The diagnosis or expected course remains unclear
- Treating providers are cautious about addressing work capacity



- Insurers minimize or question pain-related impairment

Chronic pain conditions are often multifactorial, and specialist input can help explain why symptoms persist despite treatment.

2. Specialists Can Add Depth and Context

Depending on the condition, opinions from specialists such as pain management physicians, neurologists, rheumatologists, orthopedists, psychiatrists, or others may provide insight into:

- Underlying pain mechanisms
- Expected course of the condition
- Functional consequences of ongoing pain
- Limitations of available treatment options

Specialist evaluations can help translate pain into clinical and functional terms that insurers are more likely to recognize.

3. Independent Medical Evaluations Can Provide Structured Support

An independent medical evaluation (IME) is an examination performed by a physician who is not part of an individual's routine treatment. An IME may offer:

- A structured functional assessment
- Clinical observations supporting limitations
- A consolidated summary of the condition and its impact

IME reports can be particularly helpful when treating-provider notes are brief or when insurer reviewers discount routine records.

4. Consistency Matters More Than Volume

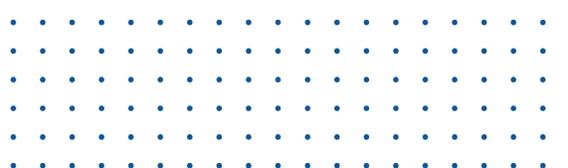
Additional opinions are most effective when they:

- Align with existing medical records
- Reinforce previously documented limitations
- Clarify rather than complicate the narrative

Multiple second opinions are not required. One well-reasoned, condition-appropriate evaluation can carry significant weight.

F. Vocational Evidence

Disability insurers evaluate whether a person can work by comparing documented medical limitations to the demands of work. Depending on the policy, this analysis may focus on the



individual's **own occupation** or on **any occupation** the insurer believes the person could reasonably perform.

For people living with chronic pain, this evaluation often misses the central issue: **whether work can be performed consistently and sustainably over time.**

1. Own Occupation vs. Any Occupation

Under an **own occupation** standard, the question is whether pain-related limitations prevent performance of the individual's specific job. Under an **any occupation** standard, insurers assess whether there is *any* work the person could reasonably perform given their background.

While the scope of the analysis differs, the underlying issue remains the same: whether pain allows reliable, ongoing work—not whether isolated tasks are possible.

2. Sustainability Is the Core Question in Pain Claims

Chronic pain often permits short periods of activity but interferes with:

- Endurance across a full day or week
- Consistent attendance
- Predictable performance
- Ability to recover sufficiently between workdays

Vocational analysis is most useful when it explains why intermittent functioning does not translate into sustainable employment.

3. Formal Vocational Reports Are Optional

Formal vocational expert reports can be helpful in some cases, particularly when an insurer suggests alternative occupations. However, these reports are **not required** and are not feasible for everyone.

A claim does not depend on the presence of a vocational expert.

4. Practical Alternatives to Expert Vocational Reports

There are many ways to document work demands and limitations without a formal vocational report, including:

- Employer job descriptions reflecting actual expectations
- Performance reviews or productivity metrics
- Attendance and scheduling policies
- Documentation of unsuccessful accommodations or reduced schedules
- Treating-provider statements addressing work capacity in general terms



These sources can help demonstrate why work—including in a prior role or in other roles, not only in the current role—is not realistically sustainable.

G. Pursuing Recommended Therapies

People living with chronic pain are often actively engaged in treatment long before disability becomes an issue. Medications, physical or occupational therapy, injections, procedures, and other interventions are frequently part of ongoing care. In disability reviews, insurers examine treatment history closely—but their assumptions about treatment do not always reflect medical reality.

1. Engagement in Treatment Does Not Equal Recovery

Insurers often view participation in treatment as evidence that improvement should follow. For chronic pain conditions, this is not always the case.

More accurately, treatment records often show that:

- Reasonable medical recommendations were followed
- Symptoms persisted despite care
- Functional capacity did not return to a sustainable level

Treatment engagement demonstrates effort and compliance, not that pain resolved or work capacity was restored.

2. Treatment Goals Are Often About Management, Not Restoration

For many chronic pain conditions, treatment aims to:

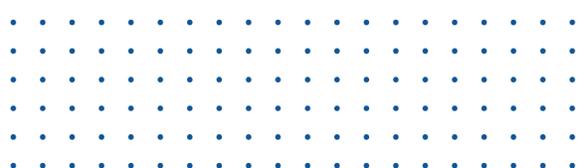
- Reduce symptom intensity (rather than completely eliminating symptoms)
- Improve quality of life
- Prevent further deterioration
- Maintain baseline functioning

These goals are different from restoring full work capacity. Documentation that reflects realistic treatment goals helps avoid assumptions that ongoing care should result in functional recovery.

3. Modifying or Stopping Treatment Can Be Appropriate

Treatment may be adjusted or discontinued for valid medical reasons, including:

- Side effects that outweigh benefits
- Increased flares or worsening pain
- Plateaued response despite compliance
- Physical or cognitive burden exceeding tolerance



When treatment changes occur, records explaining *why* help prevent misinterpretation. Stopping or modifying treatment does not indicate lack of effort; it often reflects medical judgment and lived experience.

H. Common Misinterpretations in Medical Records

Medical records are created for clinical care, not for disability evaluation. As a result, routine language and shorthand can sometimes be misunderstood when reviewed by insurers—particularly in claims involving chronic pain.

This section highlights common areas where pain-related records are misread, not because of inaccuracy, but because of missing context.

1. Language Is Often Interpreted Literally

Common phrases such as:

- “Doing well”
- “Stable”
- “Improved”
- “Symptoms controlled”

may be intended to describe short-term treatment response or lack of deterioration. In disability reviews, however, these terms are sometimes interpreted as evidence of functional recovery.

Without clarification, insurers may assume improvement in work capacity when the record simply reflects symptom management.

2. Activity Mentions Often Lack Context

Medical notes frequently reference activities (referred to as “activity mentions”) such as:

- Walking
- Exercise
- Travel
- Household tasks

But for individuals with chronic pain, these activities may:

- Occur infrequently
- Require modification or assistance
- Trigger symptom flares
- Require extended recovery time



When context is missing, insurers may overestimate functional capacity based on isolated references to activity.

3. Variability Is a Feature of Chronic Pain, Not an Inconsistency

Pain symptoms often fluctuate. Exam findings, self-reports, and functional tolerance may vary from visit to visit depending on recent activity, stress, or treatment.

Insurers sometimes characterize this variability as inconsistency. Longitudinal documentation helps show that fluctuation is an expected feature of chronic pain—not a contradiction.

III. Communicating with the Insurance Company

A. The Insurance Representative Is Not Your Advocate

When a long-term disability claim is filed, the insurance company assigns a representative to manage it. This person may come across as supportive, responsive, or empathetic. Even so, it is important to understand their role clearly.

The insurance representative's responsibility is to evaluate the claim under the policy terms—not to advocate for the claimant.

1. Understanding the Representative's Role

Insurance representatives are tasked with:

- Gathering information
- Reviewing medical records
- Applying policy definitions
- Assessing whether benefits are payable

They are not responsible for helping a claimant build the strongest possible case, or for resolving uncertainty in the claimant's favor.

This distinction helps set realistic expectations.



2. Friendly Communication Does Not Change the Review Standard

Many insurance representatives communicate in a courteous, conversational tone. While this can make the process feel collaborative, it does not alter how decisions are made.

Statements the claimant makes during:

- Phone calls
- Check-in conversations
- Informal updates

may still be documented and relied upon later.

3. Information Is Interpreted Through a Risk Lens

Insurers are managing financial risk. As a result:

- Ambiguous information may be read conservatively
- Gaps in records may be filled with assumptions
- Improvements may be emphasized over limitations

Understanding this helps explain why clarity and consistency matter when communicating.

4. You Are Not Required to Speculate or Reassure

Claimants are often asked open-ended questions about:

- How they are doing
- Whether treatment is helping
- What they expect going forward

It is appropriate to answer honestly without speculating about recovery or minimizing symptoms. Precision is more helpful than optimism.

B. Avoid Oversharing

When interacting with a disability insurer, many people feel pressure to be overly forthcoming in order to appear cooperative or credible. For individuals living with chronic pain, this instinct is understandable. At the same time, providing more information than necessary can create confusion or misinterpretation.

The goal is clarity and relevance—not volume.

1. Provide What Is Necessary and Factual

Insurers are entitled to information that relates to:



- Medical condition
- Functional limitations
- Treatment history
- Work capacity

Providing clear, factual responses to these topics is appropriate. Volunteering additional details that are unrelated, speculative, or emotionally driven can distract from the core issues and complicate the record.

Staying focused on documented facts helps keep communication aligned with the medical record.

2. Avoid Speculation About the Future

Chronic pain conditions are often unpredictable. Questions about:

- When improvement might occur
- Whether a return to work is expected
- How long symptoms may last

can later become problematic.

It is reasonable to acknowledge uncertainty and focus on current limitations and functional impact, rather than making predictions about recovery or future capacity.

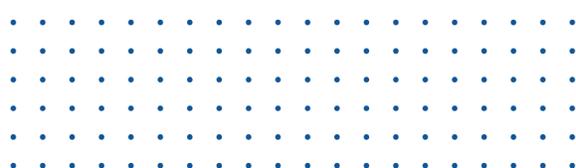
3. Consistency Matters More Than Detail

Insurers compare information across:

- Claim forms
- Phone notes
- Emails
- Medical records

Inconsistencies—rather than lack of detail—are often what draw scrutiny. Keeping responses consistent with medical documentation helps avoid misunderstandings and credibility challenges.

Accuracy and alignment matter more than exhaustive explanation. Using consistent, precise language that reflects documented limitations helps reduce misinterpretation.



Conclusion

The information in this resource is intended to provide a **general educational framework** for understanding how long-term disability claims are evaluated, particularly for individuals living with chronic pain. These topics are complex, and experiences vary widely based on medical conditions, employment circumstances, and the specific terms of an insurance policy.

This material is **not legal advice** and should not be relied upon as a substitute for advice tailored to an individual’s situation. Reading this resource does not create an attorney–client relationship.

Because every disability claim is different, individual circumstances can significantly affect how a claim should be approached. In some situations, consulting with an experienced long-term disability attorney may be helpful to obtain a personalized assessment and guidance specific to a particular policy and set of facts.

Early, informed guidance can help individuals better understand the process, avoid common misunderstandings, and make more confident decisions as they navigate a long-term disability claim.

The information provided in this booklet is for educational purposes only. It is not intended to be used as professional medical advice, diagnosis, or treatment. The perspectives shared are those of the contributing authors and may not reflect the views of the U.S. Pain Foundation. The U.S. Pain Foundation does not endorse any specific treatment or approach to treatment. For specific questions or concerns, consult your doctor.

