GUARDIAN® The Guardian Life Insurance Company of America

Group Short Term Disability Claim

Send to: Group STD Claims, P.O. Box 26160, Lehigh Valley, PA 18002-6160 **Customer Service: (800) 268-2525, Fax: (610) 807-8270**
Email: group_std_claims@GuardianLife.com

EMPLOYEE SECTION - PLEASE PRINT AND COMPLETE IN FULL TO PREVENT DELAY IN PROCESSING

1. EMPLOYEE NAME | 2. PLAN NUMBER | 3. EMPLOYER NAME

4. EMPLOYEE HOME MAILING ADDRESS CITY STATE ZIP | 5. EMPLOYEE TELEPHONE NUMBER (_____) _____-_____

6. DATE OF BIRTH _____ /_____ /_____

7. SOCIAL SECURITY NUMBER _____ - _____ - _____

8. ☐ MALE ☐ FEMALE

9. ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ LEGALLY SEPARATED ☐ DIVORCED

10. NUMBER OF DEPENDENTS UNDER AGE 18 _____

11. IS DISABILITY DUE TO YOUR EMPLOYMENT? ☐ YES ☐ NO
IF "YES", HAVE YOU FILED A WORKERS' COMPENSATION CLAIM? ☐ YES ☐ NO

12. IS DISABILITY DUE TO AN ACCIDENT? ☐ YES ☐ NO
IF "YES", DO YOU INTEND TO FILE SUIT? ☐ YES ☐ NO

13. IF YOU ANSWERED "YES" TO QUESTION (11) AND/OR (12), PLEASE PROVIDE THE FOLLOWING
DATE OF ACCIDENT TIME PLACE
ACCIDENT DETAILS

14. DATE SYMPTOMS FIRST APPEARED _____ /_____ /_____

15. RETURN TO WORK DATE ☐ ACTUAL _____ /_____ /_____ ☐ POSSIBLE

16. ARE YOU ELIGIBLE TO RECEIVE ANY OTHER INCOME (SOCIAL SECURITY, WORKERS' COMPENSATION, STATE DISABILITY, PENSION, NO-FAULT, ECT.)? ☐ YES ☐ NO
IF "YES", ATTACH A COPY OF THE AWARD LETTER OR SUPPLY TYPE OF BENEFITS, AMOUNT, FREQUENCY, TELEPHONE NUMBER, AND IDENTIFICATION NUMBER OF SOURCE (ATTACH A SEPARATE PAPER IF NEEDED)

17. IF YOUR REQUEST FOR SHORT TERM DISABILITY IS APPROVED AND YOUR BENEFIT IS TAXABLE, PLEASE GIVE AMOUNT YOU WANT US TO WITHHOLD **PER WEEK** FOR FEDERAL INCOME TAX (MUST BE WHOLE DOLLAR AMOUNT OF AT LEAST $20 PER WEEK AND MAY NOT REDUCE BENEFIT TO LESS THAN $10). **$_____ OR _____%**

18. I AUTHORIZE ANY PHYSICIAN, MEDICAL PRACTITIONER, HOSPITAL, CLINIC, OTHER HEALTH FACILITY, CONSUMER REPORTING AGENCY, THE MEDICAL INFORMATION BUREAU, SOCIAL SECURITY ADMINISTRATION, INSURANCE OR REINSURANCE COMPANY, OR EMPLOYER TO RELEASE ANY AND ALL MEDICAL AND NON-MEDICAL INFORMATION ABOUT ME IN ITS POSSESSION TO THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA OR ITS LEGAL REPRESENTATIVES. MEDICAL INFORMATION MEANS ALL INFORMATION IN THE POSSESSION OF OR DERIVED FROM PROVIDERS OF HEALTH CARE REGARDING MY MEDICAL HISTORY, MENTAL OR PHYSICAL CONDITION, OR TREATMENT. I UNDERSTAND THAT THE GUARDIAN WILL USE THE INFORMATION OBTAINED BY THIS AUTHORIZATION TO DETERMINE ELIGIBILITY FOR INSURANCE OR ELIGIBILITY FOR BENEFITS UNDER AN EXISTING PLAN. THE GUARDIAN WILL NOT RELEASE ANY INFORMATION OBTAINED TO ANY PERSON OR ORGANIZATION EXCEPT TO REINSURANCE COMPANIES, THE MEDICAL INFORMATION BUREAU, OR OTHER PERSONS OR ORGANIZATIONS PERFORMING BUSINESS OR LEGAL SERVICES IN CONNECTION WITH MY APPLICATION, CLAIM, OR AS MAY BE LAWFULLY REQUIRED OR PERMITTED, OR AS I MAY FURTHER AUTHORIZE. I KNOW THAT I MAY REQUEST AND RECEIVE A COPY OF THIS AUTHORIZATION. I AGREE THAT A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL. I AGREE THAT THIS AUTHORIZATION SHALL BE VALID FOR THE DURATION OF MY CLAIM.

"Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime. In New York, the person shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation."

SIGNATURE OF EMPLOYEE _____ DATE _____

PHYSICIAN SECTION – PLEASE COMPLETE IN FULL AND RETURN TO PREVENT DELAY IN PROCESSING

1. DIAGNOSIS(ES) | 2. ICD-9 CODE(S) | 3. HEIGHT _____ WEIGHT _____ LBS

4. IS PATIENT'S DISABILITY DUE TO A) EMPLOYMENT ☐ YES ☐ NO B) ACCIDENT ☐ YES ☐ NO C) PREGNANCY ☐ YES ☐ NO

5. IF DISABILITY IS DUE TO PREGNANCY, PLEASE INDICATE DATE OF DELIVERY ACTUAL _____ /_____ /_____ OR ESTIMATED _____ /_____ /_____ (IF UNDELIVERED)
PLEASE INDICATE LMP DATE _____ /_____ /_____ PLEASE INDICATE TYPE OF DELIVERY ☐ VAGINAL ☐ C-SECTION ☐ MULTIPLE BIRTHS

6. DATE SYMPTOMS FIRST APPEARED _____/_____/_____

7. DATE OF FIRST VISIT FOR THIS CONDITION _____ /_____ /_____

8. DATES OF TREATMENT FOR THIS CONDITION

9. DATE PATIENT WAS TOTALLY DISABLED (UNABLE TO WORK)
FROM _____ /_____ /_____ THROUGH _____ /_____ /_____

10. DATES PATIENT WAS HOSPITALIZED (IF APPLICABLE)
FROM _____ /_____ /_____ THROUGH _____ /_____ /_____

11. IF PATIENT STILL DISABLED, GIVE DATE FOR ANTICIPATED RELEASE TO RETURN TO WORK _____ /_____ /_____

12. SURGICAL PROCEDURE(S) DATE(S)/TYPE(S) CPT _____

13. A) IS THE PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? ☐ YES ☐ NO
IF "YES", ARE THERE MEDICALLY NECESSARY ACTIVITY RESTRICTIONS? ☐ YES ☐ NO
IF "YES", PLEASE SPECIFY RESTRICTIONS:

13. B) DATE OF PATIENT'S NEXT APPOINTMENT _____ /_____ /_____

14. A) WAS PATIENT REFERRED TO YOU BY ANOTHER PHYSICIAN? ☐ YES ☐ NO
IF "YES", PLEASE GIVE NAME, ADDRESS, AND TELEPHONE NUMBER OF PHYSICIAN

14. B) DID YOU REFER PATIENT TO ANOTHER PHYSICIAN? ☐ YES ☐ NO
IF "YES", PLEASE GIVE NAME, ADDRESS, AND TELEPHONE NUMBER OF PHYSICIAN

15. DO YOU BELIEVE THE PATIENT IS COMPETENT TO ENDORSE CHECKS AND DIRECT THE PROCEEDS THEREOF? ☐ YES ☐ NO

16. PRINTED NAME OF PHYSICIAN _____ SPECIALTY _____

PRINTED ADDRESS OF PHYSICIAN _____ TELEPHONE NUMBER (_____) _____-_____

FAX NUMBER (_____) _____-_____ EMAIL ADDRESS _____ TAX ID # _____

SIGNATURE OF PHYSICIAN _____ DATE _____

EMPLOYER SECTION – PLEASE PRINT AND COMPLETE IN FULL (QUESTIONS 1-24) TO PREVENT DELAY IN PROCESSING

1. EMPLOYER NAME

2. PLAN NUMBER

3. EMPLOYER ADDRESS CITY STATE ZIP

4. IF BRANCH OR AFFILIATE, PLEASE PROVIDE NAME OF PARENT COMPANY

5. EMPLOYER SOCIAL SECURITY OR TAX ID

6. EMPLOYEE NAME

7. EMPLOYEE SOCIAL SECURITY NUMBER _____ - _____ - _____

8. EMPLOYEE DATE OF BIRTH _____ /_____ /_____

9. EMPLOYEE JOB TITLE

10. DATE OF EMPLOYMENT _____ /_____ /_____

11. DATE EMPLOYEE EFFECTIVE FOR STD _____ /_____ /_____

12. EMPLOYEE INSURANCE CLASS _____

13. ACTUAL LAST DAY WORKED _____ /_____ /_____ _____ HRS

14. NORMAL WORK SCHEDULE: MON ☐ TUES ☐ WED ☐ THURS ☐ FRI ☐ SAT ☐ SUN ☐ _____ HOURS/WEEK _____ HOURS/DAY

15. DATE EMPLOYEE TERMINATED _____ /_____ /_____

16. REASON FOR LEAVING WORK: ☐ DISABILITY ☐ RESIGNED ☐ TERMINATED ☐ LAYOFF ☐ LEAVE OF ABSENCE ☐ RETIRED

17. CAN THE EMPLOYEE'S JOB BE MODIFIED TO ALLOW FOR RETURN TO WORK?
☐ YES ☐ NO ☐ MAYBE, DEPENDING ON RESTRICTIONS

18. DATE EMPLOYEE RETURNED TO WORK _____ /_____ /_____ ☐ PART TIME ☐ FULL TIME

19. SALARY – PLEASE PROVIDE: ☐ HOURLY ☐ WEEKLY ☐ BI-WEEKLY ☐ SEMI-MONTHLY ☐ MONTHLY ☐ YEARLY

EMPLOYEE'S BASE SALARY (DO NOT INCLUDE BONUS , OVERTIME OR COMMISSIONS) $_____ (PLEASE CHECK FREQUENCY ABOVE)

EMPLOYEE'S TOTAL BONUS AND COMMISSIONS OVER LAST 24 MONTHS **(IF APPLICABLE)** $_____ FROM _____ /_____ /_____ TO _____ /_____ /_____

EFFECTIVE DATE OF EMPLOYEE'S LAST SALARY CHANGE: _____

IF EARNINGS DEFINITION BASES SALARY ON PRIOR YEAR W-2, PLEASE ATTACH A COPY OF THE PRIOR YEAR W-2 (IF EMPLOYED IN PRIOR YEAR) OR PROVIDE YEAR-TO-DATE SALARY: $_____ FROM _____ /_____ /_____ TO _____ /_____ /_____

20. DOES THE EMPLOYEE CONTRIBUTE TO THE COST OF THEIR SHORT TERM DISABILITY INSURANCE PREMIUM? ☐ YES ☐ NO
IF "YES", PLEASE BE SURE TO COMPLETE THE FOLLOWING ACCURATELY AND FULLY
_____**%** PAID BY EMPLOYEE, ☐ PRE TAX ☐ POST TAX

21. DO YOU HAVE ANY REASON TO BELIEVE THAT FICA WITHHOLDING SHOULD NOT BE DEDUCTED FROM THE EMPLOYEE'S BENEFIT? ☐ YES ☐ NO
IF "YES", PLEASE EXPLAIN

22. A) DID THIS DISABILITY ARISE OUT OF EMPLOYMENT? ☐ YES ☐ NO IF "YES", PLEASE EXPLAIN

B) HAS A WORKERS' COMPENSATION CLAIM BEEN FILED? ☐ YES ☐ NO

23. I CERTIFY THAT I HAVE REVIEWED THE ABOVE INFORMATION AND THAT THE EMPLOYEE NAMED ABOVE HAS BEEN A FULL-TIME ACTIVE EMPLOYEE FOR WHOM PREMIUMS HAVE BEEN PAID.

AUTHORIZED EMPLOYER SIGNATURE _____ DATE _____

PRINTED NAME OF AUTHORIZED PERSON _____ TITLE _____

TELEPHONE NUMBER (_____) _____-_____ EXT_____ FAX NUMBER (_____) _____-_____ EMAIL ADDRESS _____

24. **JOB DESCRIPTION** – PLEASE HAVE THE FOLLOWING SECTION COMPLETED BY A SUPERVISOR WHO COULD BEST PROVIDE A DESCRIPTION OF THIS EMPLOYEE'S JOB DUTIES OR ATTACH A COMPARABLE JOB DESCRIPTION. CHECK THE BOX THAT APPLIES FOR EACH REQUIREMENT OF THE EMPLOYEE'S JOB.

	NEVER	OCCASIONALLY .25 – 2.5 DAILY HRS	FREQUENTLY 2.5 – 5.5 DAILY HRS	CONTINUOUSLY 5.5 – 8 DAILY HRS		NEVER	OCCASIONALLY .25 – 2.5 DAILY HRS	FREQUENTLY 2.5 – 5.5 DAILY HRS	CONTINUOUSLY 5.5 – 8 DAILY HRS
SIT					WALK				
STAND					DRIVE				
LIFT/CARRY	INDICATE AMOUNT/FREQUENCY BELOW				REACH ABOVE				
0-10 LBS					BEND/STOOP				
10-20 LBS					USE HANDS FOR	INDICATE ACTIVITY/FREQUENCY BELOW			
20-50 LBS					PUSHING/PULLING				
50-100 LBS					FINE MANIPULATION				
OVER 100 LBS					STRESS LEVEL ☐ LOW ☐ MODERATE ☐ HIGH ☐ VERY HIGH				

JOB DESCRIPTION COMPLETED BY _____ TITLE _____ DATE _____

NOTE: GUARDIAN WILL PROVIDE YOUR COMPANY WITH CALENDAR QUARTER AND YEAR-END THIRD PARTY SICK-PAY TAX REPORTS BY THE 15TH OF THE MONTH FOLLOWING EACH CALENDAR QUARTER, IF PAYMENTS HAVE BEEN MADE.