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."

"Please Note: Your Social Security number is required for IRS tax reporting purposes. Your Social Security number will not be used or disclosed to anyone for any other purpose and will not be retained in any record other than that pertaining to the claim."

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
SIT				
STAND				
LIFT/CARRY	INDICATE AMOUNT/FREQUENCY BELOW			
0-10 LBS				
10-20 LBS				
20-50 LBS				
50-100 LBS				
OVER 100 LBS				

	NEVER	OCCASIONALLY .25 – 2.5 DAILY HRS	FREQUENTLY 2.5 – 5.5 DAILY HRS	CONTINUOUSLY 5.5 – 8 DAILY HRS
WALK				
DRIVE				
REACH ABOVE				
BEND/STOOP				
USE HANDS FOR	INDICATE ACTIVITY/FREQUENCY BELOW			
PUSHING/PULLING				
FINE MANIPULATION				
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.