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**
Secure E-mail: www.GuardianAnytime.com, click Secure Channel, select Group_STD_Claims@glic.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, ASSOCIATION/INDIVIDUAL DISABILITY PLANS AND SALARY CONTINUATION AND/OR SICK LEAVE BENEFITS, ETC.)? ☐ 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 _____