GUARDIAN® The Guardian Life Insurance Company of America

Group Short Term Disability Claim

To expedite your claim review, STD claims may be filed on-line by visiting us at www.guardiananytime.com.
Or, you may complete the form and submit by fax to (610) 807-8270 or email to group_std_claims@glic.com
You may also send to: Group STD Claims, P.O. Box 14331, Lexington, KY 40512 **Customer Service toll-free: 1-800-268-2525**

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

EMPLOYEE EMAIL ADDRESS

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 _____%**

PLEASE NOTE: CERTAIN DISABILITY BENEFITS ARE CONSIDERED SUPPLEMENTAL WAGES BY THE IRS (SEE IRS PUBLICATION 15A). IF YOUR DISABILITY BENEFIT IS DETERMINED TO MEET THESE REQUIREMENTS, A MANDATORY FEDERAL INCOME TAX WITHHOLDING (25%) IS REQUIRED. IF YOUR CLAIM IS PAYABLE, GUARDIAN WILL ADVISE YOU AT TIME OF PAYMENT IF THIS MANDATORY WITHHOLDING APPLIES TO YOUR BENEFIT PAYMENTS.

18. 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."

PLEASE NOTE: THE ATTACHED HIPAA AUTHORIZATION MUST BE COMPLETED

SIGNATURE OF EMPLOYEE _____ DATE _____

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

1. DIAGNOSIS(ES) | 2. ICD-10 CODE(S)

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

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

5. DATE SYMPTOMS FIRST APPEARED _____/_____/_____

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

7. A) DATES OF TREATMENT FOR THIS CONDITION

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

8. HEIGHT _____
WEIGHT _____ LBS

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

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

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

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

13. A) WOULD YOU SUPPORT THE PATIENTS RETURN TO WORK ON A LIMITED BASIS? ☐ YES ☐ NO
IF "YES", PLEASE PROVIDE RESTRICTIONS AND LIMITATIONS THAT WOULD BE IN PLACE

13. B) DURATION OF ABOVE RESTRICTIONS: _____

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

14. B) DID YOU REFER PATIENT TO ANOTHER PHYSICIAN? ☐ YES ☐ NO
IF "YES", PLEASE GIVE NAME 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 _____

You may file STD claims online, and check claim status by visiting us at www.guardiananytime.com

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 EMPLOYER SOCIAL SECURITY OR TAX ID

5. DATE EMPLOYEE TERMINATED/RESIGNED

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 _____ /_____ /_____

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

15. HOURS WORKED ON LAST DAY

16. REASON FOR LEAVING WORK: ☐ DISABILITY ☐ **OTHER:** _____

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 ***100% Bonus Back non-taxable**

IF "YES", PLEASE BE SURE TO COMPLETE THE FOLLOWING ACCURATELY AND FULLY

_____**%** PAID BY EMPLOYEE, ☐ PRE TAX ☐ POST TAX

PLEASE NOTE: SELF FUNDED DISABILITY PLAN BENEFITS ARE CONSIDERED SUPPLEMENTAL WAGES BY THE IRS (SEE IRS PUBLICATION 15A). IF YOUR DISABILITY PLAN IS SELF FUNDED, GUARDIAN WILL DEDUCT A MANDATORY 25% FEDERAL INCOME TAX WITHHOLDING FROM THE DISABILITY BENEFIT CHECKS THAT ARE ISSUED.

21. FOR ASSISTANCE WITH JOB ACCOMMOCATION STAY AT WORK OPPORTUNITIES, CONTACT OUR VOCATIONAL REHABILITATION DEPT. AT 800-233-0691, OR, TO RECEIVE A CALL FROM OUR VOC REHAB DEPT., PLEASE PROVIDE US WITH THE PERSON YOU WOULD LIKE US TO CONTACT:

NAME:

PHONE:

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. **JOB DESCRIPTION** – **Please fully complete the following details about the physical aspects of the claimant's job as performed in an 8 hour work day. Please also attach a description of job duties, if available.**

	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

24. 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 _____

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GUARDIAN® The Guardian Life Insurance Company of America

Authorization to Obtain Information (Medical records and other information)

Send to: Group STD Claims, P.O. Box 14331, Lexington, KY 40512
Customer Service: (800) 268-2525 FAX: (610) 807-8270
Documents can be returned electronically at www.GuardianAnytime.com. Click on "Secure Channel" on the Guardian Anytime home page.

I authorize my physician, medical practitioner, hospital, clinic, pharmacy, other health facility, insurance or reinsurance company, group policyholder, benefit plan administrator, employer, or business associate, other person or organization to release any and all medical and non-medical information in its possession about me, to Guardian or its legal representatives. Medical information means all information in the possession of or derived from providers of health care regarding the medical history and all past and present physical, mental, drug and alcohol condition, or treatment of me. Non-medical information includes employment history, job duties, and any wage or earnings information.

I understand Guardian will use the information obtained by this authorization to determine eligibility for insurance or eligibility for benefits under an existing policy. 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 as I may fully 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 have the right to cancel this authorization in writing at any time. I agree that this authorization shall be valid up to 24 months (12 months in Kansas) from the date shown below.

"Any person who with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud."

_____ _____
Signature of Insured Date

Name _____
(Please Print)

Address _____

_____

Plan # _____ Date of Birth _____ /_____ /_____ Claim Number _____

Fraud Warning Statements

The laws of several states require the following statements to appear on the claim form:

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Arizona: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

California: For your protection California law requires the following to appear on this form: The falsity of any statement in the application shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Connecticut, Iowa, Nebraska and Oregon: Any person who knowingly, and with intent to defraud any insurance company or other person, files an application of insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, may be guilty of a fraudulent insurance act, which may be a crime, and may also be subject to civil penalties.

Delaware, Indiana and Oklahoma: WARNING: Any person who knowingly, and with the intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kansas: Any person who knowingly, and with intent to defraud any insurance company or other person, files an application of insurance or statement of claim containing any materially false information or conceals , for the purpose of misleading, information concerning any fact material thereto, may be guilty of insurance fraud as determined by a court of law.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

Louisiana and Texas: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to fines and confinements in state prison.

New Mexico: Any person who knowingly presents a false or fraudulent claim for payment or a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties or denial of insurance benefits.

Maine, Tennessee and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefit.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in N.H. Rev. Stat. Ann. § 638:20.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Ohio: Any person who with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Pennsylvania: 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 and subjects such person to criminal and civil penalties.

Rhode Island: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison

Vermont: It is a crime for any person knowingly to provide material false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company, for any person knowingly to provide material false, incomplete, or misleading information concerning the sale of insurance or the status of an insurer, or for any person to misappropriate the funds of an insured or an applicant for insurance. Penalties include imprisonment, fines, and denial of insurance benefits.

Virginia: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.