Your Guide to Filing a Long Term Disability (LTD) Claim

We recognize how important it is for you to begin receiving the Long Term Disability (LTD) benefits to which you may be entitled. Guardian would like to make this process as easy as possible for you by providing all the forms and information you will need to initiate an LTD claim, so we can thoroughly review your case and make a timely decision.

To ensure this process goes smoothly, **it is imperative that you respond to all questions fully and accurately, and send the forms back to us as soon as possible** -- you should not wait to file a claim until the elimination period has passed. The elimination period is the period of time between the onset of a disability and the time you are eligible for benefits.

How to Complete the Form

Please follow the instructions outlined below:

- **Section 1:** Claimant Statement – This section should be completed in full by you (the claimant).
- **Section 2:** Employer/Planholder Statement – This section should be provided to and completed in full by your company representative.
- **Section 3:** Attending Physician's Statement – You (the claimant) should complete the authorization section. The Attending Physician section should be provided to and completed by the physician who first treated you at the time you stopped working or when you reduced your work hours.
- **Section 4:** Direct Pay Enrollment and Authorization -- If we determine that benefits are payable, you will have the option of electing direct deposit of your benefit payments directly into your checking or savings account. Compared to traditional paper checks and postal delivery methods, direct deposit may be more convenient and a faster alternative for you. To enroll, please review and complete the Direct Pay Enrollment and Authorization form included at the end of this package.

Note: Please also attach any additional information or documentation you feel necessary to support your claim.

How to Submit Your Claim

After all sections of the form have been completed, you will need to submit it along with any supporting information or documentation to the following address:

Guardian
Group LTD Claims
PO Box 14333
Lexington, KY 40512

Documents can be returned electronically at www.GuardianAnytime.com. Click on "Secure Channel" on the Guardian Anytime home page.

If you have any questions while completing these forms, please feel free to contact our Customer Response Unit at 1-800-538-4583 for assistance. Once the claim information is received, you and your employer will be notified of receipt via a formal acknowledgement letter.

Thank you in advance for your attention.

IMPORTANT NOTICE: If you have **group term life insurance**, you may have the opportunity to convert your group life coverage to an individual life insurance policy upon termination of your life coverage. Please contact your employer/planholder **immediately** upon onset of disability to discuss your options for continuing your life insurance. The timeframe allowed for conversion is limited; please refer to your certificate booklet for details on your conversion rights. If you have any questions regarding conversion, please contact our National Conversion Unit at (800) 433-5982, ext. 5696.

GUARDIAN® The Guardian Life Insurance Company of America

Application for Long Term Disability Income Benefits

Send to: Group Long Term Disability Claims, P.O. Box 14333, Lexington, KY 40512

For Customer Service: (800) 538-4583 Fax: (610) 807-8221

Documents can be returned electronically at www.GuardianAnytime.com. Click on "Secure Channel" on the Guardian Anytime home page.

SECTION 1 - CLAIMANT STATEMENT

To be completed by the Employee/Member *(Be sure to answer ALL questions – Failure to do so may delay your claim review)*

INFORMATION ABOUT YOU

First Name	Middle Initial	Last Name	Social Security Number

Address of Residence	City	State	Zip

Telephone #	Cell # or alternate #	E-mail Address

Date of Birth (Month, Day, Year) : _____/_____/_____ ☐ Male ☐ Female ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Other legal union

Your employer: _____ Group Policy #: _____ Occupation: _____

Please indicate the extent of your formal education (circle one). This information is needed to evaluate return to work potential.

Schooling Completed: 1 2 3 4 5 6 7 8 9 10 11 12 Diploma: ☐ Yes ☐ No GED: ☐ Yes ☐ No

Vocational or Trade School: 1 2 3 4 Field of Study: _____ Certificate or license obtained ☐ Yes ☐No

College: 1 2 3 4 Degree: _____ Masters: ☐ Yes ☐No Doctorate: ☐ Yes ☐ No

Fields of Study _____

Briefly describe your past work experience for the last 20 years or attach resume. (Begin with your most recent job.)

Job Title	Duties	# of Years Worked
(a)		
(b)		
(c)		
(d)		

Spouse's First Name	Last Name	Date of Birth (Month, Day, Year)

Do you authorize us to speak with someone other than yourself regarding your claim? ☐ Yes ☐ No If yes, advise of name, relationship and telephone # below:

Name	Relationship	Telephone #

Do you have any dependent children? ☐ Yes ☐ No If yes, name and birth date of each child

Do you have an appointed Durable Power of Attorney to handle your financial affairs? ☐ Yes ☐ No If yes, please attach a copy.

INFORMATION ABOUT YOUR CLAIMED DISABILITY

Please provide the date you were first unable to work your regular work schedule due to your condition: ____/____/____ How many hours did you work that day? _____

Since that date, have you done any work? ☐Yes ☐ No If yes, indicate dates worked, name of employer, and amount earned

Before you stopped working, did your condition require you to change your job, or the way you did your job? ☐ Yes ☐ No If yes, please explain:

What job duties are you unable to perform due to your condition and why?

If you have not returned to work, do you expect to? ☐ Yes ☐ No ☐ Unknown If yes, Part time (date) _____/_____/_____ Full time (date) _____/____/____. Would you be interested in vocational rehabilitation services to assist with your return to work? ☐ Yes ☐ No

What is or are your disabling condition(s)?

What were your first symptoms?

When did you first notice your symptoms? _____ Have you had this condition before? ☐ Yes ☐ No
If yes, when?

Next to each Activity of Daily Living (ADL) listed below, please place the number that most accurately reflects your ability or inability to perform each activity:

1 = I can perform this activity independently;
2 = I can perform this activity with the use of equipment or adaptive devices;
3 = I cannot perform this activity.

____ Bathe (tub, shower, or sponge) ____ Transfer from bed to chair
____ Dress yourself ____ Voluntary bladder and bowel control or ability to maintain a reasonable level of personal hygiene
____ Use the toilet ____ Feed yourself with food that has been prepared and made available to you

Have you suffered a severe cognitive impairment that renders you unable to perform common tasks, such as using the phone, money management, or medication management? ☐ Yes ☐ No If yes, describe:

Date you were first treated by a physician for the condition for which you are claiming disability: _____/_____/_____

Name of Physician	Physician's Telephone #

Is your condition related to your employment? ☐ Yes ☐ No If yes, please explain:

Have you filed, or do you intend to file a Workers' Compensation Claim? ☐ Yes ☐ No If yes, attach a copy of the award or denial.

If your disability was caused by an accident, answer the following questions:

When, where and how did the accident occur?

If a police report was filed, attach a copy of the report. Do you intend to file suit regarding this accident? ☐ Yes ☐ No If yes, provide attorney name, address and telephone #:

INFORMATION ABOUT YOUR CARE AND TREATMENT

Family Physician Name		Specialty	
Address	City	State	Zip
Telephone #	Fax #	Dates Seen: _____/___/____ to _____/___/_____	

List all other physicians, pharmacy, and hospitals you have seen for your condition (attach separate sheet, if needed)

Physician Name		Specialty	
Address	City	State	Zip
Telephone #	Fax #	Dates Seen: _____/___/____ to _____/___/_____	

Physician name		Specialty	
Address	City	State	Zip
Telephone #	Fax #	Dates Seen: _____/___/____ to _____/___/_____	

Pharmacy Name	Telephone #	Fax #
Address	City	State Zip

Hospital Name		Dates of Hospitalization: _____/___/____ to _____/___/_____
Address	City	State Zip

OTHER INCOME/BENEFITS

Complete the sections below for any other income/benefits you have received/are receiving, or are eligible to receive during your disability. Please attach a copy of the award letter.

Source of income	Amount(week/month)	Date claim was filed	Date payments began	Date payments ended
Sick pay or salary continuation	$_____	N/A	_____	_____
Earnings from work while disabled	$_____	N/A	_____	_____
State Disability	$_____	_____	_____	_____
Short Term Disability	$_____	_____	_____	_____
Workers' Compensation	$_____	_____	_____	_____
No-Fault Insurance	$_____	_____	_____	_____
Social Security Disability	$_____	_____	_____	_____
Social Security Retirement	$_____	_____	_____	_____
Pension/Disability	$_____	_____	_____	_____
Pension/Retirement	$_____	_____	_____	_____
Unemployment	$_____	_____	_____	_____
Other _____	$_____	_____	_____	_____

Please contact us immediately if any of the above sources of income changes.

INFORMATION ABOUT TAX WITHHOLDING

Federal law requires us to withhold income tax from your check **only if you request us to do so.** We are also required to send a report to your employer at the end of each calendar year showing your name, total amount of benefits paid to you, total amount withheld, if any, and your social security number. If you want us to withhold tax, please indicate on the line below the whole dollar amount or percentage to be withheld per month. (Minimum of $20.00)

$_____.00 or _____%

FRAUD NOTICE

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statements of claim containing any materially, false information, or conceals for purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and may also be subject to civil penalties, or denial of insurance benefits.

The laws of New York require the following statement appear: 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 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.

✖_____ Date ____ / ____ / _____

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

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, Kansas, Nebraska, Oregon, and Vermont: 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.

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, Virginia 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.

Name of insured ("The Insured") | **Policy Number(s)**

Address of Insured | **Date of Birth**

Permission to Obtain and Disclose Information

I, the undersigned, AUTHORIZE any physician, medical or mental health professional, medical practitioner, hospital, clinic, healthcare or other medical or medically related facility, healthcare provider, pharmacy, pharmacy benefit manager, therapist, benefit plan administrator, business associate, insurer or reinsurer, consumer reporting agency subject to the Fair Credit Reporting Act, insurance support organization, insurance agent, employer, financial institution, Governmental Agency including The Social Security Administration, The Veteran's Administration or any other organization or person having any knowledge of The Insured or The Insured's health to give The Guardian Life Insurance Company of America ("Guardian") or its employees and agents, or its authorized representatives, or third parties, any information in its possession about The Insured. This information includes, but is not limited to, medical information as to cause, treatment, diagnoses, prognoses, consultations, examinations, tests or prescriptions with respect to The Insured's physical or mental condition or treatment of The Insured. This may include (but is not limited to) HIV infection, any disorder of the immune system, including acquired immune deficiency syndrome (AIDS), mental illness or use of alcohol or drugs. This information also includes non-medical information concerning The Insured, The Insured's occupation, employment history, driving history, earnings or finances or information otherwise needed to determine policy claim benefits that may be due The Insured.

I, the undersigned, UNDERSTAND that this authorization is part of the policy's Proof of Loss requirement and if I revoke or fail to sign this authorization or alter its content in any way, it may affect the handling of The Insured's claim, including the denial of benefits under The Insured's policy. Any information obtained will not be released by Guardian to any person or organization except to: affiliates (including but not limited to Berkshire Life Insurance Company of America); reinsuring companies; other persons (including but not limited to The Insured's attending medical provider), or insurance support organizations performing business or legal services in connection with The Insured's claim or application for insurance, or as may be otherwise lawfully required, or as I may further authorize. Information disclosed pursuant to this authorization is no longer covered by federal privacy rules and may be redisclosed pursuant to this authorization or as otherwise permitted or required by law. In the event that my coverage with Guardian requires me to pursue benefits available from the Social Security Administration, I further authorize Guardian to disclose information contained in my claim file with third parties specializing in social security disability claims.

I, the undersigned, UNDERSTAND that I have the right to revoke this authorization in writing at any time by sending a written request for revocation to Guardian at PO Box 14333 Lexington KY 40512. I understand that a revocation is not effective to the extent that Guardian has already relied on this authorization, or to the extent that the company has a legal right to contest a claim under an insurance policy or to contest the policy itself.

I, the undersigned, UNDERSTAND some states require that I be informed that: "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, may be committing a fraudulent insurance act, which is a crime and subject to criminal prosecution, substantial civil penalty and the stated value of the claim for each violation."

I, the undersigned, AGREE the information obtained with this authorization may be used by Guardian to determine eligibility for benefits under The Insured's policy. A photocopy of this form is as valid as the original, and I may request one. This form is valid up to 24 months (12 months in Kansas) from the date shown below.

I, the undersigned, AUTHORIZE the Social Security Administration to release information or records about _____ (The Insured) to Guardian or its authorized representative or third parties. This information is to be released in order to properly adjudicate The Insured's claim or continue The Insured's eligibility for benefits. Please release detailed earnings for up to the last ten years and/or summary record of total earnings and/or information from master benefit records regarding award, denial or continuing benefits. I declare that all answers, statements and information made or given by me, or at my direction, in connection with this claim are and have been complete and true.

Authorizing Signature _____ **Date** _____

Relationship or authority, if other than The Insured _____

GUARDIAN LIFE INSURANCE COMPANY OF AMERICA

Customer Electronic Consent and Disclosure Agreement

I, _____ , having applied for insurance benefits from Guardian Life Insurance Company of America ("Guardian") have expressed a desire to conduct business electronically with regard to my benefit claim ("Claim") and communications related to the Claim. In order to conduct business electronically, I hereby provide Guardian and its authorized designees and agents with my consent:

(a) to have the information described in this Customer Electronic Consent and Disclosure Agreement ("Consent") delivered to me electronically;

(b) To receive via electronic means, through email or otherwise, documents that Guardian is required by law to provide or make available to me in writing relating to the Claim or arising therefrom ("Required Documents") as well as other information and documents [collectively, ("Other Documents")];

(c) To execute via electronic means Required Documents and Other Documents and to be bound with the same force and effect as if I had affixed my signature on paper by hand when I click "I consent" or otherwise apply my electronic signature to Required Documents or Other Documents; and

(d) To all of the terms and conditions set forth below in this Consent.

Even though I have provided Guardian with this Consent, I acknowledge and agree that Guardian may, at its option: (a) deliver Required Documents and Other Documents to me on paper, and (b) require that certain communications from me be delivered to Guardian on paper.

Furthermore, I acknowledge that (1) I may expressly request that certain Required Documents or Other Documents be provided on paper at no charge and (2) this Consent shall remain in force as long as the Policy is in effect; or until I withdraw my consent by providing Guardian written notice of my withdrawal at the address stated below, and permitting Guardian at least five (5) business days from receipt within which to process my revocation; whichever occurs first:

Guardian Life Insurance Company of America
Attention: Long Term Disability Claims
PO Box 14333
Lexington KY 40512

Documents can be returned electronically at www.GuardianAnytime.com. Click on "Secure Channel" on the Guardian Anytime home page.

Software and Hardware Requirements

To access and retain Required Documents and Other Documents from Guardian, you must

1. Be able to view the disclosures on your monitor and save files to your computer or send screen prints to your printer, which can be done with your browser.
2. Have access to an Internet service using the following browsers:

Web Browser	**Operating Systems**
Internet Explorer V7 and 8	Windows XP Professional Win7 Vista
Firefox V3	Windows XP Professional Wln7 Vista Mac OS X 10.5 Mac OS X 10.6
Safari V5	Mac OS X 10.5.8 and Mac OS X 10.6
Safari V4.0.5	Mac OS X 10.5.8

3. Be able to receive e-mail that contains hyperlinks to websites in order for Guardian to deliver Required Information to you.

By my signature below, I have read this Consent and accept it voluntarily with full knowledge and understanding of its terms and conditions and assert that I have the requisite Software and Hardware.

Signature: _____ Date: _____

GUARDIAN® The Guardian Life Insurance Company of America

Send to: Group Long Term Disability Claims, P.O. Box 14333, Lexington, KY 40512
For Customer Service: (800) 538-4583 Fax: (610) 807-8221
Documents can be returned electronically at www.GuardianAnytime.com. Click on "Secure Channel" on the Guardian Anytime home page.

SECTION 2 - EMPLOYER/PLANHOLDER STATEMENT

TO BE COMPLETED BY THE EMPLOYER/PLANHOLDER

Employee/Member Name (Hereafter referred to as claimant)	Social Security Number	Date of Birth

Claimant's Address *(Street, City, State, Zip)*

INFORMATION ABOUT THE EMPLOYER / PLANHOLDER

Company's Name		Group Policy Number
Address *(Street, City, State, Zip)*		Telephone Number
Name and address of division where claimant works (if different from above)	5-digit claim branch code	Fax Number

INFORMATION ABOUT THE CLAIMANT

Date claimant was hired	Date claimant became insured under this plan	Insurance class:	Schedule at time last worked:
_____/_____/_____	_____/_____/_____		____ hours per day ____ days per week

Was the claimant insured under your prior LTD policy? ☐ Yes ☐ No If Yes, please provide the effective and termination dates of coverage: _____/_____/_____Through _____/_____/_____ Name of prior carrier:

Has the claimant been terminated? ☐ Yes ☐ No If Yes, date: _____/_____/_____ Reason:

Would you be willing to rehire this person? ☐ Yes ☐ No Reason:

Was the claimant on non-discriminatory family leave when disability began? ☐ Yes ☐ No
Date leave of absence started under Family Leave Act _____/_____/_____
Did LTD insurance continue while on family leave? ☐ Yes ☐ No

INFORMATION NEEDED FOR WITHHOLDING AND REPORTING TAXES

Contributions to the cost of this insurance:
_____% paid by employer ☐ Check here if claimant elected a bonus back/gross up arrangement (IRS Ruling 2004-55) on a Post Tax basis
_____% paid by claimant ☐ Pre-Tax ☐ Post-Tax
Is the LTD benefit exempt from FICA SS? ☐ Yes ☐ No Is the LTD benefit exempt from FICA Medicare? ☐ Yes ☐ No

INFORMATION ABOUT THE CLAIM

What was the claimant's regular job?	How long had the claimant been performing his/her regular job?

Was the claimant performing his regular job on his or her last day at work? ☐ Yes ☐ No If No, Please explain _____
If no, how long had this claimant been performing this other job? _____

Last day claimant worked	On that day, did the claimant work a full day?
_____/_____/_____	☐ Yes ☐ No If No, how many hours were worked? _____

Reason for leaving work:	Date claimant is expected/did return to work
☐dismissed ☐ leave of absence ☐ disability ☐resigned ☐ retired ☐ layoff	_____/_____/_____ Full time? ☐ Yes ☐ No Part time? ☐ Yes ☐ No

Is the claimant's condition work related?	Has a Workers' Compensation claim or similar claim been filed?
☐ Yes ☐ No	☐ Yes ☐ No If Yes, send initial report of illness or injury and award notice.

Name, address and phone number of that benefit provider

INFORMATION ABOUT YOUR PENSION PLAN *(Do not complete for maternity claim.)*

Do you have a pension plan?	If Yes, what type? (Check as many as applicable)	☐ Defined Benefit	☐ 401 K	☐ Other (specify)
☐ Yes ☐ No		☐ Defined Contribution	☐ Profit Sharing	

Is the claimant eligible for your pension plan? ☐ Yes ☐ No If No, why?	If eligible, does the claimant participate? ☐ Yes ☐ No If No, why?

If the claimant is participating, when is he or she eligible for benefits under the plan? _____/_____/_____
Is there a Disability Retirement option available to this claimant? ☐ Yes ☐ No

INFORMATION ABOUT YOUR JOB ACCOMMODATION OR RETURN-TO-WORK POLICIES

Does your company have a job-holding policy? ☐ Yes ☐ No If yes, please explain _____
What is the name, title, and telephone number of the person we should contact to discuss return to work or job accommodation opportunities?

INFORMATION ABOUT THE CLAIMANT'S SALARY

Average earnings excluding bonus, overtime and special compensation as of the most recent redetermination date:

$ _____ ☐ Week ☐ Month ☐ Year

Date of last salary increase _____/_____/____

Claimant is paid:
☐ hourly ☐ Salary ☐ W2 earnings _____
☐ by partnership ☐ commissions only* ☐ salary & commissions*
☐ salary & bonus* ☐ salary & commissions*
*Please provide average of bonus and commissions for 24 months preceding your plan's most recent redetermination date

Is this claimant eligible for salary continuation?
☐ Yes ☐ No If Yes, what is the weekly amount? $ _____ When did benefits begin? _____/_____/___ End? ___/_____/____

Has the claimant filed for Short Term Disability or State Disability benefits?
☐ Yes ☐ No If Yes, what is the weekly amount? $ _____ When did benefits begin? ____/_____/____ End? ___/_____/____

List any other sources of income to which the claimant is entitled as a result of this disability:

Information about the physical aspects of the claimant's job
Check the items below that relate to the claimant's job and complete the information requested. Use these definitions for the frequency of occurrences in an eight hour day

- **Not Applicable** means the person does not perform this activity
- **Frequently** - 2 ½ hours up to 5 ½ hours
- **Occasionally** – 15 minutes up to 2 ½ hours
- **Continuously** – 5 ½ hours and beyond

	Frequency of Occurrence			
Activity	**N/A**	**Occasionally**	**Frequently**	**Continuously**
☐ Standing	☐	☐	☐	☐
☐ Walking	☐	☐	☐	☐
☐ Sitting	☐	☐	☐	☐
☐ Balancing	☐	☐	☐	☐
☐ Bending	☐	☐	☐	☐
☐ Kneeling	☐	☐	☐	☐
☐ Crouching	☐	☐	☐	☐
☐ Crawling	☐	☐	☐	☐
☐ Reaching	☐	☐	☐	☐
☐ Working overhead	☐	☐	☐	☐
☐ Keyboard Use/Repetitive Hand Motion	☐	☐	☐	☐
☐ Climbing	☐	☐	☐	☐
☐ Driving	☐	☐	☐	☐

Activity	**Description**	**Frequency**	**Weight**
☐ Pushing	_____	_____	_____ lbs.
☐ Pulling	_____	_____	_____ lbs.
☐ Lifting	_____	_____	_____ lbs.
☐ Carrying	_____	_____	_____ lbs.

Stress level ☐ Low ☐ Moderate ☐ High ☐ Very high
Can the job be performed by alternating sitting and standing? ☐ Yes ☐ No
Claimant must use hands for repetitive action such as:

	Right		Left	
Simple grasping	☐ Yes	☐ No	☐ Yes	☐ No
Firm grasping	☐ Yes	☐ No	☐ Yes	☐ No
Fine manipulation	☐ Yes	☐ No	☐ Yes	☐ No

Use feet for repetitive movements as in operating foot controls:
Right ☐ Yes ☐ No Left ☐ Yes ☐ No Both ☐ Yes ☐ No

REQUIRED ATTACHMENTS AND SIGNATURE

Please attach a copy of the claimant's job description.
If salary is based on a W-2, K-1, 1099 or a similar document, attach a copy of the most recent document.
If you have medical information from the claimant's file relating to this disability, please attach copies.
If a work related claim is filed, send a copy of the initial report of injury or illness and award notice.

Fraud Notice
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statements of claim containing any materially, false information, or conceals for purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and may also be subject to civil penalties, or denial of insurance benefits.
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_____ Name (Please print or type)
_____ Title
_____ Email Address
_____ Signature
_____ Date

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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, Kansas, Nebraska, Oregon, and Vermont: 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.

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, Virginia 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.

GUARDIAN® The Guardian Life Insurance Company of America

Send to: Group Long Term Disability Claims, P.O. Box 14333, Lexington, KY 40512
For Customer Service: (800) 538-4583 Fax: (610) 807-8221
Documents can be returned electronically at www.GuardianAnytime.com. Click on "Secure Channel" on the Guardian Anytime home page.

SECTION 3 - ATTENDING PHYSICIAN'S STATEMENT

PATIENT AUTHORIZATION (This part to be completed by the claimant: The patient is responsible for the cost of completing this form)

Name of Patient	Date of Birth

Address of Patient	City	State	Zip

Employer/Planholder Name	Group Policy #

I, the undersigned "patient", AUTHORIZE any physician, medical or mental health professional, medical practitioner, hospital, clinic, healthcare or other medical or medically related facility, healthcare provider, pharmacy, pharmacy benefit manager, therapist, benefit plan administrator, business associate, insurer or reinsurer, consumer reporting agency subject to the Fair Credit Reporting Act, insurance support organization, insurance agent, employer, financial institution, Governmental Agency including The Social Security Administration, The Veteran's Administration or any other organization or person having any knowledge of me or my health to give The Guardian Life Insurance Company of America ("Guardian"), or its employees and agents, or its authorized representatives or third parties, any information in its possession about me. This information includes, but is not limited to, medical information as to cause, treatment, diagnoses, prognoses, consultations, examinations, tests or prescriptions with respect to my physical or mental condition or treatment of me. This may include (but is not limited to) HIV infection, any disorder of the immune system, including acquired immune deficiency syndrome (AIDS), mental illness or use of alcohol or drugs. This information also includes non-medical information concerning me, my occupation, employment history, driving history, earnings or finances or information otherwise needed to determine policy claim benefits that may be due me. I agree that a photocopy of this form is as valid as the original, and that this form is valid up to 24 months (12 months in Kansas) from the date shown below.

Signed (Patient)	Date

THIS PART TO BE COMPLETED BY THE ATTENDING PHYSICIAN

THIS PART TO BE COMPLETED BY THE ATTENDING PHYSICIAN

Patient's condition is the result of: ☐ Illness ☐ Injury ☐ Pregnancy
Is the condition due to a work related illness or injury? ☐ Yes ☐ No
If pregnancy, indicate LMP date: _____ /_____ /_____ Delivery Date: _____ /____ / _____ ☐ Expected ☐ Actual
Type of delivery: ☐ Vaginal ☐ C-Section ☐ Single Birth ☐ Multiple Births

DIAGNOSIS

Primary diagnosis: _____ ICD-10 Code: _____
Secondary diagnosis(es): _____ ICD-10 Code: _____
Subjective symptoms: _____
Physical examination findings: _____
Test results (list all results, or enclose test):
Test: _____ Date: _____ Results: _____
Test: _____ Date: _____ Results: _____

TREATMENT

Date of onset of this condition: _____ / _____ / _____	Date you first treated this patient for this condition: _____ / _____ / _____
Date of most recent visit: _____ / _____ / _____	Date of next office visit: _____ / _____ / _____

Frequency of visits/treatment for this condition: ☐ Weekly ☐ Monthly ☐ Other _____

Was patient referred to you by another physician? ☐ Yes ☐ No If yes, provide name, address, phone # and fax #:

Have you referred this patient to any other physician? ☐ Yes ☐ No If yes, Date(s): _____ /_____ / _____ ____ /____ / _____

Physician Name	Specialty

Address *(Street, City, State, Zip)*	Phone #

Describe treatment plan (Include medication, therapy, counseling, rehab, etc.):

Has surgery been performed? ☐ Yes ☐ No If yes, Date: ____ /____ / ____ Procedure: _____ CPT Code: _____
Was patient hospitalized for this condition? ☐ Yes ☐ No If yes, Date(s) admitted: ____ /____ / ____ Date(s) discharged: ____ /____ / ____
____ /____ / ____ ____ /____ / ____

Name of Hospital

Address	City	State	Zip

Progress (please check one): ☐ Recovered ☐ Improved ☐ Unchanged ☐ Retrogressed
Patient is (please check one): ☐ Ambulatory ☐ Bed confined ☐ House confined ☐ Hospital confined
☐ Nursing Home/Assisting Living confined ☐ Other _____

LEVEL OF FUNCTIONAL IMPAIRMENT

Did you advise the patient to a) reduce work hours? ☐ Yes ☐ No If yes, as of what date? _____ /_____ / _____

b) cease work? ☐ Yes ☐ No If yes, as of what date? _____ /_____ / _____

c) work light duty? ☐ Yes ☐ No If yes, as of what date? _____ /_____ / _____

Degree of Physical Impairment: In an 8-hour work day, your patient can:

Lift/carry (in pounds) ☐1-10 ☐11-20 ☐ 21-50 ☐ 51-75 ☐ 76+
Push/pull (in pounds) ☐1-10 ☐11-20 ☐ 21-50 ☐ 51-75 ☐ 76+

	Total hours with positional changes								
Sit	8	7	6	5	4	3	2	1	(hrs)
Stand	8	7	6	5	4	3	2	1	(hrs)
Walk	8	7	6	5	4	3	2	1	(hrs)
Alternately sit/stand	8	7	6	5	4	3	2	1	(hrs)

Bend/stoop: ☐ Never ☐ Occasionally ☐ Frequently
Reach: ☐ Never ☐ Occasionally ☐ Frequently
Drive: ☐ Never ☐ Occasionally ☐ Frequently
Dominant Hand: ☐ Right ☐ Left

Other restrictions: _____

Duration of restrictions: _____

Degree of Psychiatric Impairment if applicable (check one):

☐ Inadequate information to make assessment
☐ Essentially good functioning in all areas. Occupationally and socially effective.
☐ Slight difficulty in occupational functioning, but generally functioning well. Has some meaningful interpersonal relationships.
☐ Moderate impairment in occupational functioning. Limited in performing some occupational duties.
☐ Major impairment in several areas—work, family relations. Avoidant behavior, neglects family, is unable to work.
☐ Inability to function in almost all areas.

Current GAF (Global Assessment of Functioning): ___/90 Highest GAF in past year: ___/90

Do you believe that this patient is competent to endorse checks and direct the use of the proceeds? ☐ Yes ☐ No

Degree of Cardiac Functional Impairment (check one):

☐ Class 1 (No limitation); ☐ Class 2 (Slight limitation); ☐ Class 3 (Marked limitation); ☐ Class 4 (Complete limitation)

Please supply patient's height: _____ weight _____ blood pressure _____ / _____; EF _____% date _____

Return to Work Expectation

In your opinion, does the patient have some capacity for work: ☐ Yes ☐ No

If yes, as of what date: _____ / _____ / _____ ☐ Full-time _____ / _____ / _____ ☐ Part-time

If no, when do you anticipate the patient will have capacity for work? ____ /____ /_____ ☐ Full-time ☐ Part-time ☐ Never

PLEASE ATTACH PERTINENT MEDICAL RECORDS INCLUDING, BUT NOT LIMITED TO, PROGRESS NOTES, DIAGNOSTIC TEST RESULTS, DISCHARGE SUMMARIES, OPERATIVE REPORTS, CONSULTATION REPORTS AND MENTAL STATUS EXAM (IF APPLICABLE). THIS WILL HELP TO EXPEDITE THE CLAIM PROCESSING AND REDUCE ADDITIONAL REQUESTS AND FOLLOW UP.

Physician's Name	Degree	Specialty

Address	City	State	Zip

Telephone #	Fax #	Tax ID #

Remarks:

FRAUD NOTICE

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statements of claim containing any materially, false information, or conceals for purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and may also be subject to civil penalties, or denial of insurance benefits.

The laws of New York require the following statement appear: 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 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.

x _____ Date _____/ _____/ _____

Signature of Physician (no stamp)

Fraud Warning Statements

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

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GUARDIAN® The Guardian Life Insurance Company of America

Group LTD Claims
P.O. Box 14333
Lexington, KY 40512

Direct Pay Enrollment and Authorization

For direct deposit of your Long Term Disability (LTD) benefit payments to your checking or savings account, please include all of the information requested. Check the appropriate box for either checking or savings account. Please allow 4 to 8 weeks for processing. Once approved for direct deposit, you can expect your benefit payment in your account approximately 3-5 business days prior to your pay through date.

1. Claim Information:

Claim Number*: _____

Claimant Name*: _____

2. Provide the following bank information*:

Account Type:

☐ Checking Account
(include a blank personal check marked "void") *See the check diagram to the right to identify the bank routing number and your account number*

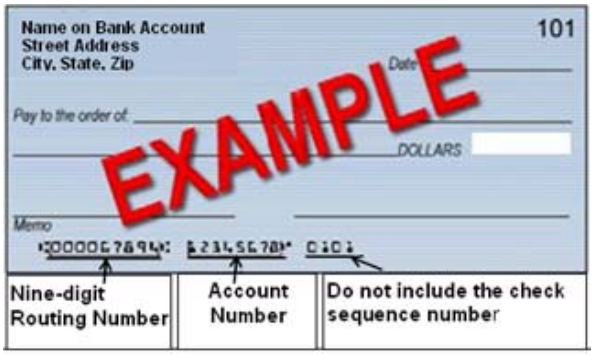
☐ Savings Account
(include a copy of a bank deposit slip with account number & routing number or a letter from your bank with this required information)

Bank Name: _____

Bank Routing Number (ABA#): _____

Bank Account Number: _____

**Required Information*



3. Sign and date this authorization:

I authorize Guardian Life Insurance Company of America ("Company") to deposit any benefits I am eligible to receive directly into the account and bank I have indicated above or to such other account as the bank or any successor bank designates as my account. I also authorize the Company to debit my account for any deposits made in error. I also understand that the direct deposit service will stay in effect until I notify the Company in writing of cancellation or until I am no longer eligible for or due payments, whichever comes first. I understand that I have the opportunity to view my EOBs and payment history on GuardianAnytime.com.

☐ Check this box to discontinue receiving paper EOBs.

_____ _____
Claimant Signature Date

4. Joint Account Holder Agreement (Please check here if you are the sole account holder) ☐

I understand and agree that any funds deposited after the date of death of the Claimant that are not otherwise payable under the plan are to be immediately returned to Guardian Life Insurance Company of America.

_____ _____
Joint Account Holder Signature Date

5. Return the completed Authorization by mail:

Guardian Life Insurance Company of America
Group LTD Claims
P.O. Box 14333
Lexington, KY 40512

Documents can be returned electronically at www.GuardianAnytime.com. Click on "Secure Channel" on the Guardian Anytime home page.