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 26160, Lehigh Valley, PA 18002-6160 **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** _____**%**

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 HAVE THE RIGHT TO CANCEL THIS AUTHORIZATION IN WRITING AT ANY TIME. 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 _____

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## 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 _____

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# Fraud Warning Statements

**The laws of several states require the following statements to appear on forms, as a substitute for fraud warnings that appear in other areas of the claim form:**

**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 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.

**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 and 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.

**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 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.

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

**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.