

Send to: Group STD Claims, P.O. Box 26160, Lehigh Valley, PA 18002-6160
 Secure E-mail: www.GuardianAnytime.com, click Secure Channel, select Group STD_Claims@glic.com

Customer Service: (800) 268-2525, Fax: (610) 807-8270

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. <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	9. <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> LEGALLY SEPARATED <input type="checkbox"/> DIVORCED	10. NUMBER OF DEPENDENTS UNDER AGE 18 _____	
11. IS DISABILITY DUE TO YOUR EMPLOYMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO IF "YES", HAVE YOU FILED A WORKERS' COMPENSATION CLAIM? <input type="checkbox"/> YES <input type="checkbox"/> NO			12. IS DISABILITY DUE TO AN ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO IF "YES", DO YOU INTEND TO FILE SUIT? <input type="checkbox"/> YES <input type="checkbox"/> 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 <input type="checkbox"/> ACTUAL ____/____/____ <input type="checkbox"/> 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.)? <input type="checkbox"/> YES <input type="checkbox"/> 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 <input type="checkbox"/> YES <input type="checkbox"/> NO B) ACCIDENT <input type="checkbox"/> YES <input type="checkbox"/> NO C) PREGNANCY <input type="checkbox"/> YES <input type="checkbox"/> 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 <input type="checkbox"/> VAGINAL <input type="checkbox"/> C-SECTION <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO IF "YES", ARE THERE MEDICALLY NECESSARY ACTIVITY RESTRICTIONS? <input type="checkbox"/> YES <input type="checkbox"/> NO IF "YES", PLEASE SPECIFY RESTRICTIONS:		14. A) WAS PATIENT REFERRED TO YOU BY ANOTHER PHYSICIAN? <input type="checkbox"/> YES <input type="checkbox"/> NO IF "YES", PLEASE GIVE NAME, ADDRESS, AND TELEPHONE NUMBER OF PHYSICIAN	
13. B) DATE OF PATIENT'S NEXT APPOINTMENT ____/____/____		14. B) DID YOU REFER PATIENT TO ANOTHER PHYSICIAN? <input type="checkbox"/> YES <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> 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 <input type="checkbox"/> TUES <input type="checkbox"/> WED <input type="checkbox"/> THURS <input type="checkbox"/> FRI <input type="checkbox"/> SAT <input type="checkbox"/> SUN <input type="checkbox"/> _____ HOURS/WEEK _____ HOURS/DAY	
15. DATE EMPLOYEE TERMINATED ____/____/____		16. REASON FOR LEAVING WORK: <input type="checkbox"/> DISABILITY <input type="checkbox"/> RESIGNED <input type="checkbox"/> TERMINATED <input type="checkbox"/> LAYOFF <input type="checkbox"/> LEAVE OF ABSENCE <input type="checkbox"/> RETIRED	
17. CAN THE EMPLOYEE'S JOB BE MODIFIED TO ALLOW FOR RETURN TO WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> MAYBE, DEPENDING ON RESTRICTIONS		18. DATE EMPLOYEE RETURNED TO WORK ____/____/____ <input type="checkbox"/> PART TIME <input type="checkbox"/> FULL TIME	
19. SALARY – PLEASE PROVIDE: 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 ____/____/____		<input type="checkbox"/> HOURLY <input type="checkbox"/> WEEKLY <input type="checkbox"/> BI-WEEKLY <input type="checkbox"/> SEMI-MONTHLY <input type="checkbox"/> MONTHLY <input type="checkbox"/> YEARLY	
20. DOES THE EMPLOYEE CONTRIBUTE TO THE COST OF THEIR SHORT TERM DISABILITY INSURANCE PREMIUM? <input type="checkbox"/> YES <input type="checkbox"/> NO IF "YES", PLEASE BE SURE TO COMPLETE THE FOLLOWING ACCURATELY AND FULLY _____ % PAID BY EMPLOYEE, <input type="checkbox"/> PRE TAX <input type="checkbox"/> POST TAX		21. DO YOU HAVE ANY REASON TO BELIEVE THAT FICA WITHHOLDING SHOULD NOT BE DEDUCTED FROM THE EMPLOYEE'S BENEFIT? <input type="checkbox"/> YES <input type="checkbox"/> NO IF "YES", PLEASE EXPLAIN	
22. A) DID THIS DISABILITY ARISE OUT OF EMPLOYMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO IF "YES", PLEASE EXPLAIN B) HAS A WORKERS' COMPENSATION CLAIM BEEN FILED? <input type="checkbox"/> YES <input type="checkbox"/> 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	<input type="checkbox"/> LOW	<input type="checkbox"/> MODERATE	<input type="checkbox"/> HIGH	<input type="checkbox"/> 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.

CLAIM FRAUD WARNING STATEMENTS

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

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.

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, 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 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.