

Send to: Group STD Claims, P.O. Box 26160, Lehigh Valley, PA 18002-6160

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

Email: group_std_claims@GuardianLife.com

EMPLOYEE SECTION - PLEASE PRINT AND COMPLETE <u>IN FULL</u> 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, ECT.)? <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 AGREE THAT THIS AUTHORIZATION SHALL BE VALID FOR THE DURATION OF MY CLAIM.									
"Any person who knowingly and with the 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."									
SIGNATURE OF EMPLOYEE _____ DATE _____									
PHYSICIAN SECTION - PLEASE COMPLETE <u>IN FULL</u> 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 <u>ACTIVITY RESTRICTIONS</u> ? <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: <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 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? <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.