GUARDIAN® The Guardian Life Insurance Company of America

STD Attending Physician's Statement of Disability

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

1. Employee Name	2. Date of Birth	3. Plan Number/Claim Number	4. Social Security Number
	____ /____ /____		- -

AUTHORIZATION

I authorize any physician, medical practitioner, hospital, clinic, other health facility, consumer reporting agency, the Social Security Administration, the Medical Information Bureau, insurance or reinsurance company, or employer to release any and all medical and non-medical information in its possession about me 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 the medical history, mental or physical condition, or treatment of me. I understand that Guardian will use the information obtained by this authorization to determine eligibility for insurance or eligibility for benefits under an existing plan. 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: _____ Date: _____

PHYSICIAN SECTION

We are reviewing a Short Term Disability Claim for your above named patient and require an update on his/her current condition.

1. Date Total Disability Began:	2. Date of First Treatment:	3. Date of Most Recent Evaluation:	4. Frequency of Treatment: ☐ Weekly ☐ Monthly ☐ Other (specify): _____	5. Next Appointment:

6. Is this patient **totally** disabled from his/her ☐ Sedentary ☐ Light ☐ Medium ☐ Heavy ☐ Very Heavy-Occupation of _____

☐ No, Date Released for RTW: _____ ☐ Full-time ☐ Part-time Restrictions, if applicable: _____

☐ Yes, Project RTW Date: _____ ☐ Full-time ☐ Part-time Restrictions, if applicable: _____

7. Has Patient's condition: ☐ Recovered ☐ Improved ☐ Not Changed ☐ Retrogressed

8. **Current** Disabling Diagnosis/ICD9 (code(s)

_____

9. **Current** Objective Findings to Support Continued Total Disability (Please attach copies of diagnostic study reports if applicable):

10. **Current** Treatment Plan (Please be specific, including surgeries (CPT codes)/procedures with dates, medications, therapy, etc.):

11. Did you refer patient to another physician for treatment or evaluation of the **current** disabling condition? ☐ Yes ☐ No If "yes", please provide:

Physician Name	**Specialty**	**Address**	**Phone Number**

12. ***Please Attach or Provide Additional Information as Specified below:***

☐ Records from ____ /____ /____ to ____ /____ /____ ☐ Include diagnostic study and operative reports. ☒ Most recent office visit notes.

☐ Other, as specified _____

13. Physician Information: Physician Name (Please Print): _____ Specialty: _____

Signature: _____ Date: ____ /____ /____

Address: _____ City: _____ State: _____ Zip: _____

Telephone Number: ( ) _____ - _____ Fax Number: ( ) _____ - _____ Email Address: _____