GUARDIAN™ The Guardian Life Insurance Company of America

Group Long Term Disability Claim

Send to the Long Term Disability Claim Office, Box 26025, Lehigh Valley, Pa 18002-6025
Customer Service: (800) 538-4583 Fax: (610) 807-8221
E-mail: Group_LTD_Claims@glic.com

EMPLOYEE SECTION	**Notify Guardian when you return to work**		
1. Employee's Name:			2. Plan #:
3. Date of Birth:	4. Social Security #:	5. ☐ Male ☐ Female	6. ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Legally Separated
7. Employee's Address:			8. Home Telephone #:
9. Describe first symptoms of illness or injury:			
10. Nature of illness or injury:	11. Date of injury or first noticed symptoms of illness:		12. Date first treated for this illness or injury:
13. Date you became unable to work because of this illness or injury:	14. Was illness or injury related to your employment? ☐ Yes ☐ No If "Yes", have you filed a Workers' Compensation Claim? ☐ Yes ☐ No Do you intend to file a Workers' Compensation Claim? ☐ Yes ☐ No If "No" why not?		
15. Have you ever had the same or similar condition in the past? ☐ Yes ☐ No Date of first treatment ____ / ____ / ____ If yes, please provide names, addresses and telephone numbers of physicians who first treated you.			
16. If you have engaged in any other work since illness or injury began, explain and give dates:	17. Date you returned to work: Part Time ____ / ____ / ____ Full Time ____ / ____ / ____		18. Date you expect to return to work: Part Time ____ / ____ / ____ Full Time ____ / ____ / ____
19. Give your exact job title and explain the duties of your occupation when your illness or injury began:			
20. Name and date of birth of spouse and dependent children: Spouse _____ ____ / ____ / ____ Child _____ ____ / ____ / ____ Child _____ ____ / ____ / ____ Child _____ ____ / ____ / ____			
21. Name, complete address and telephone number of family physician:			
22. Names, complete addresses and telephone numbers of physicians and hospitals that treated you for this illness or injury:			
23. Describe any other income you are receiving or are eligible to receive as a result of your disability (e.g., Social Security, Workers' Compensation, State Disability, Pension, Disability/Retirement, Group Disability, No-Fault). Attach copy of award or denial. Source Plan # Claim # Amount/How Often Date Claim Filed Date Income Began Date Income Ended			
24. If your request for Long Term Disability benefits is approved, amount you want us to withhold from each payment for federal income tax **(must be whole dollar amount of at least $20)**. If no amount is indicated, FIT will not be withheld. $_____ (or %) _____ Signature of Employee: _____ Date: _____			

25. I authorize any physician, medical practitioner, hospital, clinic, other health facility, consumer reporting agencies, the Medical Information Bureau, 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 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 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. In California, any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

_____ _____
Signature of Employee Date

EMPLOYER SECTION	**Send the Attending Physician's Statement (Form NRO 117) and the employee's job description, and award or denial letter for other income benefits with this form.**

1. Planholder/Employer Name: | 2. Plan #:

3. Planholder/Employer Address: City State Zip

4. Telephone #:
Fax #:

5. If branch or affiliate, name and relationship to parent company:

6. Name & address of branch where employee works:

7. Employer Tax I.D. #:

8. Employee's name:

9. Date of birth:

10. Date of full time employment:

11. Insurance class:

12. Date insurance effective under this plan:

13. If insured with Guardian less than 12 months please provide:
Prior carrier Name Employee's eff. date

14. Job Title at time last worked:
Attach Job Description

15. Schedule at time last worked:
_____ hours per day
_____ days per week

16. Date disability began:

17. Date last worked:

18. Reason for leaving work:
☐ dismissed ☐ leave of absence ☐ disability
☐ resigned ☐ retired ☐ layoff

19. Date employment terminated:

20. Has the employee returned to work? ☐ Yes ☐ No If "Yes", on what date _____ /_____ /_____ ☐ Part Time ☐ Full Time
Is the employee performing all job duties required prior to disability? ☐ Yes ☐ No

21. Average earnings excluding bonus, overtime, and special compensation as of last day worked:
$ ☐ Week ☐ Month ☐ Year
Date of last salary increase _____

22. Employee is paid:
☐ hourly ☐ by partnership
☐ salary ☐ commissions only
☐ salary & commissions ☐ salary & bonus
☐ salary, bonus & commission

23. Contributions to the cost of this insurance:
____% paid by employer
____% paid by employee
☐ Pre-Tax ☐ Post-Tax

24. Is employee eligible for salary continuation? ☐ Yes ☐ No
. Dates eligible for salary continuation: Begins _____ Ends _____
Amount of salary continuation: $_____ ☐ Week ☐ Month

25. If employee receives Workers' Compensation: WC claim # _____ Weekly amount _____
Date comp. began _____ Date comp. ended _____
Name, address and telephone # of WC carrier: _____

26. If employee is eligible for Pension, is it:
☐ Disability ☐ Retirement ☐ Other _____

27. If employee contributes to Pension, percent attributed to employee contribution: _____%

28. Date employee was eligible for Pension

29. Pension benefits paid:
☐ Monthly ☐ Annually ☐ Lump Sum
☐ Amount $_____

30. Benefit begins:

31. Benefit ends:

32. Name, type, and complete address of Pension Fund:

Federal law requires a third-party payer, such as an insurance company, to withhold income taxes from sick pay payments if the employee so requests. Sick pay includes Short Term (Weekly Loss of Time) and Long Term Disability benefits provided under an employer-sponsored group insurance plan as well as statutory disability benefits.

An employee who elects to have federal income taxes withheld from disability benefit payments must provide the information requested in Question No. 26 in the Employee Section. We will withhold the requested amount until the employee notifies us in writing to modify or terminate the request.

If coverage is provided to employees under the terms of a collective bargaining agreement, an employee need not request withholding provided that the agreement specifies that IRC section 3402(0)(5), the sick pay withholding provision, will apply to sick pay paid pursuant to the agreement and provided also that the agreement states the manner in which the amount withheld is to be determined. Notify Guardian how much income tax to withhold and provide the Social Security Number of the employee from whom we are to withhold taxes.

The law also requires us to give you a written report by January 15 of the year succeeding that in which disability payments were made. Our report will give the name of each employee who received disability payments, the total amount of benefits paid, and the total amount of income tax withheld from each employee's payments. If taxes were withheld from an employee's disability payments, we must also give you the employee's social security number.

By January 31, you must provide a W-2 statement to each employee who has received disability payments. The W-2 must contain all the information you received from us and must show which portion, if any, of the employee's disability payments is excludable from gross pay and which is not. Contact your tax consultant if you have any questions about sick pay withholding.

33. Remarks:

34. I agree to notify Guardian when the employee receives a benefit from the Pension Fund and when the employee is no longer required to contribute to it. I certify that I have reviewed the employee section and that the employee named above has been a full-time, active employee for whom premiums have been paid. **If this claim is found to be compensable, checks should be sent to:** ☐ The employee's home ☐ The employer

Please Print Name: _____

Signature and Title: _____ Date: _____