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
Secure E-mail: www.GuardianAnytime.com, click Secure Channel, select 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 %) _____

"**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."

Important Notice: If you are age 60 or over, please contact your employer within 31 days of disability, as you may be entitled to convert your group term life insurance. Please refer to your certificate booklet for details on your conversion rights.

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. I have the right to cancel this authorization in writing at any time.

"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 may also be subject to civil penalties, or denial of insurance benefits."

The laws of New York require the following statement appear: 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 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.

_____ _____
Signature of Employee Date

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.

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. 24 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: _____