The Guardian®

Form No. GG-011096
Group Short Term Disability Claim

SEND TO THE GROUP SHORT TERM DISABILITY CLAIM OFFICE SHOWN ON THE FIRST PAGE OF THE GROUP ADMINISTRATION MANUAL.

EMPLOYEE SECTION

Notify The Guardian when you return to work.

1. PLANHOLDER/EMPLOYER NAME

2. PLAN NUMBER
G-

3. EMPLOYEE'S NAME

4. DATE OF BIRTH

5. SOCIAL SECURITY NO.

6. ☐ MALE ☐ FEMALE

7. ☐ SINGLE ☐ WIDOWED ☐ MARRIED ☐ DIVORCED ☐ LEGALLY SEPARATED

8. EMPLOYEE'S ADDRESS
CITY STATE ZIP

9. HOME TELEPHONE NO.
( ) –

10. DESCRIBE FIRST SYMPTOMS OF ILLNESS OR ACCIDENT.

11. NATURE OF ILLNESS OR ACCIDENT

12. DATE OF ACCIDENT OR DATE FIRST NOTICED SYMPTOMS OF ILLNESS

13. WAS ACCIDENT OR ILLNESS RELATED TO YOUR EMPLOYMENT? ☐ YES ☐ NO
IF YES, PLEASE EXPLAIN.

14. DATE FIRST TREATED FOR THIS ILLNESS OR INJURY

15. DATE YOU BECAME UNABLE TO WORK BECAUSE OF THIS DISABILITY

16. DATE YOU RETURNED TO WORK PART TIME

17. DATE YOU RETURNED TO WORK FULL TIME

18. DATE YOU EXPECT TO RETURN TO WORK PART TIME

19. DATE YOU EXPECT TO RETURN TO WORK FULL TIME

20. IF YOU HAVE ENGAGED IN ANY OTHER WORK SINCE DISABILITY BEGAN, EXPLAIN AND GIVE DATES.

21. EXPLAIN THE DUTIES OF YOUR OCCUPATION WHEN YOUR DISABILITY BEGAN.

22. NAME AND COMPLETE ADDRESS OF FAMILY PHYSICIAN

23. NAMES AND COMPLETE ADDRESSES OF PHYSICIANS AND HOSPITALS THAT FIRST TREATED YOU FOR THIS ILLNESS OR INJURY

24. HAVE YOU EVER HAD THE SAME OR A SIMILAR CONDITION IN THE PAST? ☐ YES ☐ NO IF "YES," PLEASE PROVIDE NAMES & COMPLETE ADDRESSES OF PHYSICIANS WHO TREATED YOU.

25. 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).

Source	*Plan No.*	*Claim No.*	*Amount/How often*	*Date claim filed*	*Date income began*	*Date income ended*

26. IF YOUR REQUEST FOR SHORT 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 AND MAY NOT REDUCE PAYMENT TO LESS THAN $10). $ (or %)

SIGNATURE OF EMPLOYEE DATE

27. I authorize any physician, medical practitioner, hospital, clinic, other health facility, consumer reporting agency, 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 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 intent to defraud any insurance company or other person files a statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, may be committing a criminal act.

SIGNATURE OF EMPLOYEE DATE

REV 1/91

EMPLOYER SECTION

If your plan has Direct Certification, complete questions 11, 13, 16, 19, 21, & 24 only.

1. PLANHOLDER/EMPLOYER NAME

2. PLAN NUMBER
G-

3. PLANHOLDER/EMPLOYER ADDRESS CITY STATE ZIP

4. TELEPHONE NUMBER
( ) -

5. IF BRANCH OR AFFILIATE, NAME & RELATIONSHIP TO PARENT COMPANY

6. EMPLOYER SOCIAL SECURITY OR TAX I.D. NO.

7. EMPLOYEE'S NAME

8. DATE OF BIRTH

9. DATE OF EMPLOYMENT

10. CERTIFICATE NO.

11. INSURANCE CLASS

12. DATE INSURANCE EFFECTIVE UNDER THIS PLAN

13. OCCUPATION AT TIME LAST WORKED

14. WORK SCHEDULE AT TIME LAST WORKED _____ HOURS PER DAY, _____ DAYS PER WEEK

15. DATE DISABILITY BEGAN

16. DATE LAST WORKED

17. REASON FOR LEAVING WORK
☐ DISMISSED ☐ LEAVE OF ABSENCE ☐ DISABILITY
☐ RESIGNED ☐ RETIRED ☐ LAYOFF

18. DATE TERMINATED FOR DISABILITY

19. LAST FULL DAY OF DISABILITY

20. HAS THE EMPLOYEE RETURNED TO WORK? ☐ YES ☐ NO IF "YES," ☐ PART TIME ☐ FULL TIME IS THE EMPLOYEE PRESENTLY PERFORMING ALL DUTIES PERFORMED PRIOR TO DISABILITY? ☐ YES ☐ NO

21. AVERAGE EARNINGS EXCLUDING BONUS, OVERTIME, AND SPECIAL COMPENSATION ON THE REDETERMINATION DATE OF YOUR PLAN
$ ☐ WEEK ☐ MONTH ☐ YEAR

22. EMPLOYEE IS PAID
☐ HOURLY ☐ BY PARTNERSHIP
☐ SALARY ☐ COMMISSIONS ONLY
☐ SALARY & COMMISSIONS ☐ SALARY & BONUS

23. IF EMPLOYEE CONTRIBUTES TO COST OF THIS INSURANCE,
____% PAID BY EMPLOYEE
____% PAID BY EMPLOYER

24. 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.

AUTHORIZED SIGNATURE AND TITLE _____ DATE _____

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 The 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 benefit 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.

PHYSICIAN SECTION

Please complete this form and return it to your patient.

1. PHYSICIAN'S NAME

2. PHYSICIAN'S ADDRESS CITY STATE ZIP

3. TELEPHONE NUMBER
( ) -

4. SOCIAL SECURITY OR TAX I.D. NO.

5. NAME OF REFERRING PHYSICIAN

6. DATE OF PATIENT'S ILLNESS (FIRST SYMPTOM), OR INJURY (ACCIDENT), OR PREGNANCY (LMP)

7. DATE FIRST CONSULTED YOU FOR THIS CONDITION

8. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS?
☐ YES ☐ NO

9. DATE PATIENT ABLE TO RETURN TO WORK

10. DATES OF TOTAL DISABILITY
FROM THROUGH

11. DATES OF PARTIAL DISABILITY
FROM THROUGH

12. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY

13. LIST DATES OF ALL TREATMENTS FOR THIS CONDITION

14. PLEASE SIGN AND DATE

SIGNATURE OF PHYSICIAN _____ DATE _____