



Send to: Group Long Term Disability Claims, P.O. Box 26025, Lehigh Valley, PA 18002-6025
 For Customer Service: (800) 538-4583 Fax: (610) 807-8221 Email: Group_LTD_Claims@GuardianLife.com

EMPLOYEE SECTION

1. Employee Name		2. DOB ___/___/___	3. Plan #
4. Address	City	State	Zip
			5. Phone # ()
6. Employer Name			7. Occupation

AUTHORIZATION

8. 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.

"It is a crime for any person knowingly to provide material false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company, for any person knowingly to provide material false, incomplete, or misleading information concerning the sale of insurance or the status of an insurer, or for any person to misappropriate the funds of an insured or an applicant for insurance. Penalties include imprisonment, fines, and denial of insurance benefits."

Signature _____ Date ___/___/___

PHYSICIAN SECTION Completion of this form will help to expedite processing of the claim and reduce additional requests and follow up. Your patient is responsible for the cost of completing this form.

1. Diagnosis (including any complications)	ICD9 or DSM IV Codes:
2. Medical evidence that substantiates or contributes to this patient's inability to work (please attach results of x-rays, MRIs, EKGs, etc.)	
3. Subjective Complaints	

CONDITION HISTORY

4. Patient's symptoms are the result of (check all that apply)	
<input type="checkbox"/> Employment	<input type="checkbox"/> Pregnancy
<input type="checkbox"/> Illness	<input type="checkbox"/> Motor Vehicle Accident
	<input type="checkbox"/> Other Accident
	<input type="checkbox"/> Other _____
5. Date symptoms first appeared or accident occurred ___/___/___	6. Date of your first evaluation for this condition ___/___/___
7. Frequency of visit/treatment for this condition <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other _____	8. Date of most recent visit/treatment for this condition ___/___/___
9. If inability to work is due to pregnancy, please indicate <input type="checkbox"/> expected <input type="checkbox"/> actual (check one) delivery date: ___/___/___ Type of delivery (if applicable) <input type="checkbox"/> Vaginal <input type="checkbox"/> C-section <input type="checkbox"/> Single Birth <input type="checkbox"/> Multiple Births	
10. Has this patient ever had a similar or related condition? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", when ___/___/___ Explain:	
11. Was this patient referred to you by another physician? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please supply physician's complete name and address, specialty, phone # and fax #:	
12. Did you refer this patient to another physician/or provider for treatment of this or a related condition? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please supply the physician's/provider's complete name and address, phone # and fax #:	

13. Please supply complete name, address and specialty of any other treating physicians or hospitals including phone # and fax #.

Name	Specialty	Address	Phone #	Fax #	From	Treatment To
_____	_____	_____	_____	_____	___/___/___	___/___/___
_____	_____	_____	_____	_____	___/___/___	___/___/___
_____	_____	_____	_____	_____	___/___/___	___/___/___

If additional space is needed, please attach a separate sheet

TREATMENT

14. Describe this patient's treatment program: (including any surgeries with date and CPT codes) _____

 Medications _____ Counseling _____
 Therapies _____ Vocational rehabilitation _____

PROGRESS

15. Patient has Recovered Not Changed
 Improved Retrogressed

16. Patient is Ambulatory House Confined Other _____
 Bed Confined Hospital Confined

17. Did you place the patient on off work status? Yes No

18. If yes, what date? ____ / ____ / ____

19. Has patient been released to return to work? Yes No

If "Yes", date patient was released to return to work? ____ / ____ / ____

Part Time Usual Occupation
 Full Time Other Occupation
 Other _____

20. If not yet released to return to work, when do you anticipate a release? ____ / ____ / ____ Part Time Full Time Never

21. Physical LIMITATIONS that preclude RETURN TO WORK

Class 1 No limitation of functional capacity; capable of heavy work* no restrictions (0-10%)
 Class 2 Medium manual activity* (15-30%)
 Class 3 Slight limitation of functional capacity; capable of light work* (35-55%)
 Class 4 Moderate limitations of functional capacity; capable of clerical/administrative (sedentary*) activity (60-70%)
 Class 5 Severe limitations of functional capacity; incapable of minimal (sedentary*) activity (75-100%)

Remarks

*As defined in the Federal Dictionary of Occupational Titles

22. Degree of **mental/nervous impairment** Current GAF (**Global Assessment of Functioning**) _____/90 Please attach mental status exam.
 Axis 1 _____ Axis 3 _____
 Axis 2 _____ Axis 4 _____

23. Do you believe that this patient is competent to endorse checks and direct the use of the proceeds? Yes No

24. Degree of **Cardiac Functional Capacity** (American Heart Association)
 Class 1 (No Limitation) Class 2 (Slight Limitation) Class 3 (Marked Limitation) Class 4 (Complete Limitation)
 Please supply patient's: height _____ weight _____ blood pressure _____

PLEASE ATTACH PERTINENT MEDICAL RECORDS INCLUDING BUT NOT LIMITED TO PROGRESS NOTES, DIAGNOSTIC TEST RESULTS, DISCHARGE SUMMARIES, OPERATIVE REPORTS, CONSULTATION REPORTS AND MENTAL STATUS EXAM (IF APPLICABLE). THIS WILL HELP TO EXPEDITE PROCESSING OF CLAIM AND REDUCE ADDITIONAL REQUESTS AND FOLLOW UP. YOUR PATIENT IS RESPONSIBLE FOR THE COST OF THE MEDICAL RECORDS.

PHYSICIAN INFORMATION

25. Physician's Name		26. Degree	27. Specialty	
28. Address		29. City	30. State	31. Zip
32. Telephone # ()	33. Fax # ()	34. Tax ID #		

35. Remarks**FRAUD NOTICE**

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. This includes Employee and Attending Physician portions of the form.

* _____ Date ____ / ____ / ____
 Signature of Physician (no stamp)