Your Guide to Filing a Long Term Disabilityit is imperative that you respond to all
back to us as soon as possible -- you should not wait to file a claim until the elimination
The elimination period is the period of time between the onset of a disability and the time you
ts.

Form

ructions outlined below:

Claimant Statement – This section should be completed in full by you (the claimant).

Employer/Planholder Statement – This section should be provided to and completed in full by your company representative.

Attending Physician's Statement – You (the claimant) should complete the authorization section. The Attending Physician section should be provided to and completed by the physician who first treated you at the time you stopped working or when you reduced your work hours.

- Section 4: Direct Pay Enrollment and Authorization -- If we determine that benefits are payable, you will have the option of electing direct deposit of your benefit payments directly into your checking or savings account. Compared to traditional paper checks and postal delivery methods, direct deposit may be more convenient and a faster alternative for you. To enroll, please review and complete the Direct Pay Enrollment and Authorization form included at the end of this package.

Note: Please also attach any additional information or documentation you feel necessary to support your claim.

How to Submit Your Claim

After all sections of the form have been completed, you will need to submit it along with any supporting information or documentation to the following address:

Guardian
Group LTD Claims
PO Box 14333
Lexington, KY 40512

Or via our secure email site at: www.GuardianAnytime.com
When you go to the site, click Secure Channel and select Group_LTD_Claims@glic.com

If you have any questions while completing these forms, please feel free to contact our Customer Response Unit at 1-800-538-4583 for assistance. Once the claim information is received, you and your employer will be notified of receipt via a formal acknowledgement letter.

Thank you in advance for your attention.

IMPORTANT NOTICE: If you have group term life insurance , you may have the opportunity to convert your group life coverage to an individual life insurance policy upon termination of your life coverage. Please contact your employer/planholder immediately upon onset of disability to discuss your options for continuing your life insurance. The timeframe allowed for conversion is limited; please refer to your certificate booklet for details on your conversion rights. If you have any questions regarding conversion, please contact our National Conversion Unit at (800) 433-5982, ext. 5696.

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Fraud Warning Statements

The laws of several states require the following statements to appear on the claim form:

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

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: The falsity of any statement in the application shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer.

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 lbraska, Ore (mpa001Tca)

Name of insured (“The Insured”)

Policy Number(s)

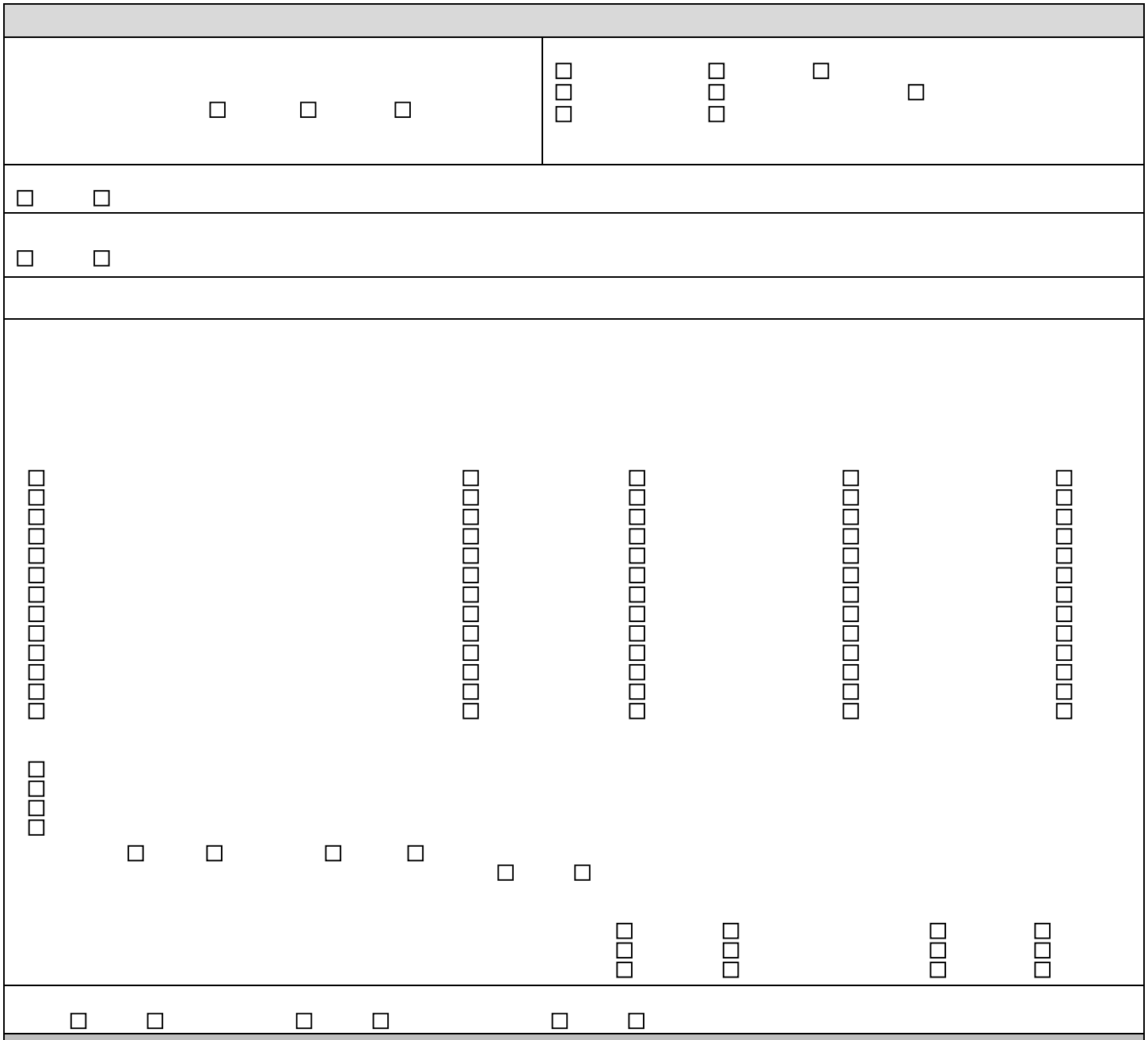
Address of Insured

Date of Birth

Permission to Obtain and Disclose Information

I, the undersigned, AUTHORIZE any physician, medical or mental health professional, medical practitioner, hospital, clinic, healthcare or other medical or medically related facility, healthcare provider, pharmacy, pharmacy benefit manager, therapist, benefit plan administrator, business associate, insurer or reinsurer, consumer reporting agency subject to the Fair Credit Reporting Act, insurance support organization, insurance agent, employer, financial institution, Governmental Agency including The Social Security Administration, The Veteran’s Administration or any other organization or person having any knowledge of The Insured or The Insured’s health to give The Guardian Life Insurance Company of America (“Guardian”) or its employees and agents, or its authorized representatives, or third parties, any information in its possession about The Insured. This information includes, but is not limited to, medical information as to cause, treatment, diagnoses, prognoses, consultations, examinations, tests or prescriptions with respect to The Insured’s physical or mental condition or treatment of The Insured. This may include (but is not limited to) HIV infection, any disorder of the immune system, including acquired immune deficiency syndrome (AIDS), mental illness or use of alcohol or drugs. This information also includes non-medical information concerning The Insured, The Insured’s occupation, employment history, driving history, earnings or finances or information otherwise needed to determine policy claim benefits that may be due The Insured.

I, the undersigned, UNDERSTAND that this authorization is part of the policy’s Proof of Loss requirement and if I revoke



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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.

Kentucky: 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 commits a fraudulent insurance act, which is a crime.

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.

New Mexico: Any person who knowingly presents a false or fraudulent claim for payment or a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties or denial of insurance benefits.

Maine, Tennessee, 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: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly or 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.

Ohio: Any person who with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

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.

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.

GUARDIAN® The Guardian Life Insurance Company of America

Send to: Group Long Term Disability Claims, P.O. Box 14333, Lexington, KY 40512
For Customer Service: (800) 538-4583 Fax: (610) 807-8221
Secure E-mail: www.GuardianAnytime.com, click Secure Channel, select Group_LTD_Claims@glic.com

SECTION 3 - ATTENDING PHYSICIAN'S STATEMENT

PATIENT AUTHORIZATION (This part to be completed by the claimant: The patient is responsible for the cost of completing this form)

Name of Patient	Date of Birth
Address of Patient City State Zip	
Employer/Planholder Name	Group Policy #

I, the undersigned "patient", AUTHORIZE any physician, medical or mental health professional, medical practitioner, hospital, clinic, healthcare or other medical or medically related facility, healthcare provider, pharmacy, pharmacy benefit manager, therapist, benefit plan administrator, business associate, insurer or reinsurer, consumer reporting agency subject to the Fair Credit Reporting Act, insurance support organization, insurance agent, employer, financial institution, Governmental Agency including The Social Security Administration, The Veteran's Administration or any other organization or person having any knowledge of me or my health to give The Guardian Life Insurance Company of America ("Guardian"), or its employees and agents, or its authorized representatives or third parties, any information in its possession about me. This information includes, but is not limited to, medical information as to cause, treatment, diagnoses, prognoses, consultations, examinations, tests or prescriptions with respect to my physical or mental condition or treatment of me. This may include (but is not limited to) HIV infection, any disorder of the immune system, including acquired immune deficiency syndrome (AIDS), mental illness or use of alcohol or drugs. This information also includes non-medical information concerning me, my occupation, employment history, driving history, earnings or finances or information otherwise needed to determine policy claim benefits that may be due me. I agree that a photocopy of this form is as valid as the original, and that this form is valid up to 24 months (12 months in Kansas) from the date shown below.

Signed (Patient)	Date

THIS PART TO BE COMPLETED BY THE ATTENDING PHYSICIAN

THIS PART TO BE COMPLETED BY THE ATTENDING PHYSICIAN
Patient's condition is the result of: ☐ Illness ☐ Injury ☐ Pregnancy
Is the condition due to a work related illness or injury? ☐ Yes ☐ No

If pregnancy, indicate LMP date: _____ /_____ /_____ Delivery Date: _____ /____ / _____ ☐ Expected ☐ Actual

Type of delivery? ☐ Vaginal ☐ C-Section Patient may AN No Del. 12 s, the LMP prior n 2D, late 4 Pr (Sapien) 9 4 (ate LMP and (a 45 8 B 15.4)

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LEVEL OF FUNCTIONAL IMPAIRMENT

Did you advise the patient to a) reduce work hours? ☐ Yes ☐ No If yes, as of what date? _____ /_____ / _____

b) cease work? ☐ Yes ☐ No If yes, as of what date? _____ /_____ / _____

c) work light duty? ☐ Yes ☐ No If yes, as of what date? _____ /_____ / _____

Degree of Physical Impairment: In an 8-hour work day, your patient can:

Lift/carry (in pounds) ☐1-10 ☐11-20 ☐ 21-50 ☐ 51-75 ☐ 76+

Push/pull (in pounds) ☐1-10 ☐11-20 ☐ 21-50 ☐ 51-75 ☐ 76+

Total hours with positional changes

Sit	8	7	6	5	4	3	2	1	(hrs)
Stand	8	7	6	5	4	3	2	1	(hrs)
Walk	8	7	6	5	4	3	2	1	(hrs)
Alternately sit/stand	8	7	6	5	4	3	2	1	(hrs)

Bend/stoop: ☐ Never ☐ Occasionally ☐ Frequently

Reach: ☐ Never ☐ Occasionally ☐ Frequently

Drive: ☐ Never ☐ Occasionally ☐ Frequently

Dominant Hand: ☐ Right ☐ Left

Other restrictions: _____

Duration of restrictions: _____

Degree of Psychiatric Impairment if applicable (check one):

☐ Inadequate information to make assessment
☐ Essentially good functioning in all areas. Occupationally and socially effective.
☐ Slight difficulty in occupational functioning, but generally functioning well. Has some meaningful interpersonal relationships.
☐ Moderate impairment in occupational functioning. Limited in performing some occupational duties.
☐ Major impairment in several areas—work, family relations. Avoidant behavior, neglects family, is unable to work.
☐ Inability to function in almost all areas.

Current GAF (Global Assessment of Functioning): ___/90 Highest GAF in past year: ___/90

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

Degree of Cardiac Functional Impairment (check one):

☐ Class 1 (No limitation); ☐ Class 2 (Slight limitation); ☐ Class 3 (Marked limitation); ☐ Class 4 (Complete limitation)

Please supply patient's height: _____ weight _____ blood pressure _____ / _____; EF _____% date _____

Return to Work Expectation

In your opinion, does the patient have some capacity for work: ☐ Yes ☐ No

If yes, as of what date: _____ / _____ / _____ ☐ Full-time _____ / _____ / _____ ☐ Part-time

If no, when do you anticipate the patient will have capacity for work? ____ /____ /_____ ☐ Full-time ☐ Part-time ☐ Never

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

Physician's Name	Degree	Specialty

Address	City	State	Zip

Telephone #	Fax #	Tax ID #

Remarks:

FRAUD NOTICE

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statements of claim containing any materially, false information, or conceals for 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.

x _____ Date _____/ _____/ _____

Signature of Physician (no stamp)

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GUARDIAN® The Guardian Life Insurance Company of America

Group LTD Claims
P.O. Box 14333
Lexington, KY 40512

Direct Pay Enrollment and Authorization

For direct deposit of your Long Term Disability (LTD) benefit payments to your checking or savings account, please include all of the information requested. Check the appropriate box for either checking or savings account. Please allow 4 to 8 weeks for processing.

1. Claim Information:

   Claim Number*: _____

   Claimant Name*: _____

2. Provide the following bank information *:

   Account Type:

   ☐ Checking Account
   (include a blank personal check marked "void") See the check diagram to the right to identify the bank routing number and your account number

   ☐ Savings Account
   (include the routing and account numbers as provided by your bank)

   Bank Name: _____

   Bank Routing Number (ABA#): _____

   Bank Account Number: _____

   *Required Information

3. Sign and date this authorization:

   I authorize Guardian Life Insurance Company of America ("Company") to deposit any benefits I am eligible to receive directly into the account and bank I have indicated above or to such other account as the bank or any successor bank designates as my account. I also author

_____ _____

_____ _____