Group Benefit Associates

3963 W. Belmont Ave., Suite 6
Chicago, IL 60618

DISABILITY CLAIM FORM INSTRUCTIONS

The disability income insurance claim form is composed of three separate sections that need to be completed by you, your physician and your employer.

- Employee Section: Please be sure to complete this part clearly and sign where indicated.
- Physician Section: Please have the physician that disabled you complete this part. If you have seen additional physicians, please also include their names, addresses, phone numbers and fax numbers on a separate sheet of paper.
- Employer Section: Even though your policy is purchased through the union, your benefit is based on the income you receive from your particular employer. Your employer assumes no liability or responsibility for your claim by completing this form for you.

Failure to provide proper information and documentation will delay your claim so it is very important the claim form is complete and clear. Once complete, forward the form to our office by mail, fax or a scanned copy by e-mail to:

Group Benefit Associates
3963 W. Belmont Ave., Suite 6
Chicago, IL 60618
773-427-6875 fax
support@groupba.com

HOW YOUR CLAIM WILL BE HANDLED:
Once received by Group Benefit Associates, we will begin waiving your premium as of the date of your disability. The processing of your claim will be handled by Guardian Life Insurance Company and therefore you may inquire with them regarding the status of your claim. Please note that Group Benefit Associates does not have access to information regarding claims determination or benefit payments. However, the assistance of our office can be requested if you encounter difficulty in getting your claim processed. Guardian can be reached Monday through Friday from 8am to 5pm Eastern Standard Time at:

Short-Term Claims Department (for claims payable during the first 6 months of disability)
800-268-2525 phone/ 610-807-8270 fax
Long-Term Claims Department (for claims payable after 6 months of disability)
800-538-4583 phone/ 610-807-9221 fax

Premium billing questions are handled by Group Benefit Associates at 800-450-1271.

GUARDIAN™ The Guardian Life Insurance Company of America

Group Short Term Disability Claim

Send to: Group STD Claims, PO Box 26160, Lehigh Valley, PA 18002-6160
Customer Service: 1-800-268-2525 Email: group_std_claims@glic.com FAX: 610-807-8270

EMPLOYEE SECTION - PLEASE PRINT AND COMPLETE IN FULL TO PREVENT DELAY IN PROCESSING

1. EMPLOYEE NAME
2. PLAN NUMBER
3. EMPLOYER NAME

4. EMPLOYEE HOME MAILING ADDRESS CITY STATE ZIP
5. EMPLOYEE TELEPHONE NUMBER (________) ________-____________

6. DATE OF BIRTH _______/______/_______
7. SOCIAL SECURITY NUMBER __________/_________/__________
8. ☐ MALE ☐ FEMALE
9. ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ LEGALLY SEPARATED ☐ DIVORCED
10. Number of Dependents Under Age 18 ________________

11. IS DISABILITY DUE TO YOUR EMPLOYMENT? ☐ YES ☐ NO
IF "YES", HAVE YOU FILED A WORKERS' COMPENSATION CLAIM? ☐ YES ☐ NO

12. IS DISABILITY DUE TO AN ACCIDENT? ☐ YES ☐ NO
IF "YES", DO YOU INTEND TO FILE SUIT? ☐ YES ☐ NO

13. IF YOU ANSWERED "YES" TO QUESTION (11) AND/OR (12), PLEASE PROVIDE THE FOLLOWING
DATE OF ACCIDENT TIME PLACE
ACCIDENT DETAILS

14. DATE SYMPTOMS FIRST APPEARED _______/________/_______

15. RETURN TO WORK DATE ☐ ACTUAL _______/_______/______ ☐ POSSIBLE

16. ARE YOU ELIGIBLE TO RECEIVE ANY OTHER INCOME (SOCIAL SECURITY, WORKERS' COMPENSATION, STATE DISABILITY, PENSION, NO-FAULT, ECT.)? ☐ YES ☐ NO
IF "YES", ATTACH A COPY OF THE AWARD LETTER OR SUPPLY TYPE OF BENEFITS, AMOUNT, FREQUENCY, TELEPHONE NUMBER, AND IDENTIFICATION NUMBER OF SOURCE (ATTACH A SEPARATE PAPER IF NEEDED)

17. IF YOUR REQUEST FOR SHORT TERM DISABILITY IS APPROVED AND YOUR BENEFIT IS TAXABLE, PLEASE GIVE AMOUNT YOU WANT US TO WITHHOLD **PER WEEK** FOR FEDERAL INCOME TAX (MUST BE WHOLE DOLLAR AMOUNT OF AT LEAST $20 PER WEEK AND MAY NOT REDUCE BENEFIT TO LESS THAN $10). **$_________ OR _________%**

18. I AUTHORIZE ANY PHYSICIAN, MEDICAL PRACTITIONER, HOSPITAL, CLINIC, OTHER HEALTH FACILITY, CONSUMER REPORTING AGENCY, THE MEDICAL INFORMATION BUREAU, SOCIAL SECURITY ADMINISTRATION, 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 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.

SIGNATURE OF EMPLOYEE____ DATE ______________________

PHYSICIAN SECTION – PLEASE COMPLETE IN FULL AND RETURN TO PREVENT DELAY IN PROCESSING

1. DIAGNOSIS(ES)
2. ICD-9 CODE(S)
3. HEIGHT __________ WEIGHT ________LBS

4. IS PATIENT'S DISABILITY DUE TO A) EMPLOYMENT ☐ YES ☐ NO B) ACCIDENT ☐ YES ☐ NO C) PREGNANCY ☐ YES ☐ NO

5. IF DISABILITY IS DUE TO PREGNANCY, PLEASE INDICATE DATE OF DELIVERY ACTUAL______/______/______ OR ESTIMATED______/______/______ (IF UNDELIVERED)
PLEASE INDICATE LMP DATE ______/_______/______ PLEASE INDICATE TYPE OF DELIVERY ☐ VAGINAL ☐ C-SECTION ☐ MULTIPLE BIRTHS

6. DATE SYMPTOMS FIRST APPEARED _______/_______/_______
7. DATE OF FIRST VISIT FOR THIS CONDITION _______/______/_______
8. DATES OF TREATMENT FOR THIS CONDITION

9. DATE PATIENT WAS TOTALLY DISABLED (UNABLE TO WORK)
FROM ______/______/______ THROUGH ______/______/______

10. DATES PATIENT WAS HOSPITALIZED (IF APPLICABLE)
FROM ______/______/______ THROUGH ______/______/______

11. IF PATIENT STILL DISABLED, GIVE DATE FOR ANTICIPATED RELEASE TO RETURN TO WORK ______/______/______

12. SURGICAL PROCEDURE(S) DATE(S)/TYPE(S) CPT ________________________

13. A) IS THE PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? ☐ YES ☐ NO
IF "YES", ARE THERE MEDICALLY NECESSARY ACTIVITY RESTRICTIONS? ☐ YES ☐ NO
IF "YES", PLEASE SPECIFY RESTRICTIONS:

13. B) DATE OF PATIENT'S NEXT APPOINTMENT ______/______/______

14. A) WAS PATIENT REFERRED TO YOU BY ANOTHER PHYSICIAN? ☐ YES ☐ NO
IF "YES", PLEASE GIVE NAME, ADDRESS, AND TELEPHONE NUMBER OF PHYSICIAN

14. B) DID YOU REFER PATIENT TO ANOTHER PHYSICIAN? ☐ YES ☐ NO
IF YES, PLEASE GIVE NAME, ADDRESS, AND TELEPHONE NUMBER OF PHYSICIAN

15. DO YOU BELIEVE THE PATIENT IS COMPETENT TO ENDORSE CHECKS AND DIRECT THE PROCEEDS THEREOF? ☐ YES ☐ NO

16. PRINTED NAME OF PHYSICIAN____ SPECIALTY__________________________

PRINTED ADDRESS OF PHYSICIAN______________________________________ TELEPHONE NUMBER (___________)_________-______________

FAX NUMBER (___________)_________-______________ EMAIL ADDRESS ________________________ TAX ID # ________________________

SIGNATURE OF PHYSICIAN____DATE__________________________

EMPLOYER SECTION – PLEASE PRINT AND COMPLETE IN FULL (QUESTIONS 1-24) TO PREVENT DELAY IN PROCESSING

1. EMPLOYER NAME
2. PLAN NUMBER

3. EMPLOYER ADDRESS　CITY　STATE　ZIP

4. IF BRANCH OR AFFILIATE, PLEASE PROVIDE NAME OF PARENT COMPANY
5. EMPLOYER SOCIAL SECURITY OR TAX ID

6. EMPLOYEE NAME
7. EMPLOYEE SOCIAL SECURITY NUMBER ________/_______/________
8. EMPLOYEE DATE OF BIRTH ______/______/______

9. EMPLOYEE JOB TITLE
10. DATE OF EMPLOYMENT ________/________/________
11. DATE EMPLOYEE EFFECTIVE FOR STD ________/________/_________
12. EMPLOYEE INSURANCE CLASS ________________

13. ACTUAL LAST DAY WORKED ________/________/________ _______ HRS

14. NORMAL WORK SCHEDULE: MON ☐ TUES ☐ WED ☐ THURS ☐ FRI ☐ SAT ☐ SUN ☐ _______________ HOURS/WEEK _______________ HOURS/DAY

15. DATE EMPLOYEE TERMINATED________/________/________

16. REASON FOR LEAVING WORK: ☐ DISABILITY ☐ RESIGNED ☐ TERMINATED ☐ LAYOFF ☐ LEAVE OF ABSENCE ☐ RETIRED

17. CAN THE EMPLOYEE'S JOB BE MODIFIED TO ALLOW FOR RETURN TO WORK? ☐ YES ☐ NO ☐ MAYBE, DEPENDING ON RESTRICTIONS

18. DATE EMPLOYEE RETURNED TO WORK ________/________/_________ ☐ PART TIME ☐ FULL TIME

19. SALARY – PLEASE PROVIDE: ☐ HOURLY ☐ WEEKLY ☐ BI-WEEKLY ☐ SEMI-MONTHLY ☐ MONTHLY ☐ YEARLY

EMPLOYEE'S BASE SALARY (DO NOT INCLUDE BONUS , OVERTIME OR COMMISSIONS) $____________________ (PLEASE CHECK FREQUENCY ABOVE)

EMPLOYEE'S TOTAL BONUS AND COMMISSIONS OVER LAST 24 MONTHS (IF APPLICABLE) $_____________________ FROM________/________/________ TO ________/________/_______

EFFECTIVE DATE OF EMPLOYEE'S LAST SALARY CHANGE: ________________________

IF EARNINGS DEFINITION BASES SALARY ON PRIOR YEAR W-2, PLEASE ATTACH A COPY OF THE PRIOR YEAR W-2 (IF EMPLOYED IN PRIOR YEAR) OR PROVIDE YEAR-TO-DATE SALARY: $_________________ FROM________/________/________ TO ________/________/______

20. DOES THE EMPLOYEE CONTRIBUTE TO THE COST OF THEIR SHORT TERM DISABILITY INSURANCE PREMIUM? ☐ YES ☐ NO
IF YES, PLEASE BE SURE TO COMPLETE THE FOLLOWING ACCURATELY AND FULLY
_________________% PAID BY EMPLOYEE, ☐ PRE TAX ☐ POST TAX

21. DO YOU HAVE ANY REASON TO BELIEVE THAT FICA WITHHOLDING SHOULD NOT BE DEDUCTED FROM THE EMPLOYEE'S BENEFIT? ☐ YES ☐ NO
IF YES, PLEASE EXPLAIN

22. A) DID THIS DISABILITY ARISE OUT OF EMPLOYMENT? ☐ YES ☐ NO IF YES, PLEASE EXPLAIN
B) HAS A WORKERS' COMPENSATION CLAIM BEEN FILED? ☐ YES ☐ NO

23. I CERTIFY THAT I HAVE REVIEWED THE ABOVE INFORMATION AND THAT THE EMPLOYEE NAMED ABOVE HAS BEEN A FULL-TIME ACTIVE EMPLOYEE FOR WHOM PREMIUMS HAVE BEEN PAID.

AUTHORIZED EMPLOYER SIGNATURE____DATE____________________

PRINTED NAME OF AUTHORIZED PERSON____ TITLE____________________

TELEPHONE NUMBER (________)_______-__________EXT_________ FAX NUMBER (_______)_______-_________ EMAIL ADDRESS ______________________________

24. **JOB DESCRIPTION** – PLEASE HAVE THE FOLLOWING SECTION COMPLETED BY A SUPERVISOR WHO COULD BEST PROVIDE A DESCRIPTION OF THIS EMPLOYEE'S JOB DUTIES OR ATTACH A COMPARABLE JOB DESCRIPTION. CHECK THE BOX THAT APPLIES FOR EACH REQUIREMENT OF THE EMPLOYEE'S JOB.

	NEVER	OCCASIONALLY .25 – 2.5 DAILY HRS	FREQUENTLY 2.5 – 5.5 DAILY HRS	CONTINUOUSLY 5.5 – 8 DAILY HRS
SIT				
STAND				
LIFT/CARRY	INDICATE AMOUNT/FREQUENCY BELOW			
0-10 LBS				
10-20 LBS				
20-50 LBS				
50-100 LBS				
OVER 100 LBS				

	NEVER	OCCASIONALLY .25 – 2.5 DAILY HRS	FREQUENTLY 2.5 – 5.5 DAILY HRS	CONTINUOUSLY 5.5 – 8 DAILY HRS
WALK				
DRIVE				
REACH ABOVE				
BEND/STOOP				
USE HANDS FOR	INDICATE ACTIVITY/FREQUENCY BELOW			
PUSHING/PULLING				
FINE MANIPULATION				
STRESS LEVEL	☐ LOW	☐ MODERATE	☐ HIGH	☐ VERY HIGH

JOB DESCRIPTION COMPLETED BY______________________________________TITLE______________________________DATE____________________

NOTE: GUARDIAN WILL PROVIDE YOUR COMPANY WITH CALENDAR QUARTER AND YEAR-END THIRD PARTY SICK-PAY TAX REPORTS BY THE 15TH OF THE MONTH FOLLOWING EACH CALENDAR QUARTER, IF PAYMENTS HAVE BEEN MADE.