

Send to: Group STD Claims, P.O. Box 14331, Lexington, KY 40512

Customer Service: (800) 268-2525, Fax: (610) 807-8270

Documents can be returned electronically at [www.guardianlife.com/forms](http://www.guardianlife.com/forms). Select the "Benefits through work" option and click the "Secure Channel" link to send your private information.

<b>EMPLOYEE SECTION</b>				
1. Employee Name	2. Date of Birth ____/____/____	3. Plan Number	4. Claim Number	
<b>AUTHORIZATION</b>				
<p>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 have the right to cancel this authorization in writing at any time. I agree that this authorization shall be valid up to 24 months (12 months in Kansas) from the date shown below.</p> <p><b>"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."</b></p> <p>Signature: _____ Date: _____</p>				
<b>PHYSICIAN SECTION</b>				
<b>We are reviewing a Short Term Disability Claim for your above named patient and require an update on his/her current condition.</b>				
1. Date Total Disability Began:	2. Date of First Treatment:	3. Date of Most Recent Evaluation:	4. Frequency of Treatment: <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other (specify): _____	5. Next Appointment:
<b>6. Please Attach or Provide Additional Information as Specified below:</b> <input checked="" type="checkbox"/> Records from ____/____/____ to ____/____/____ <input type="checkbox"/> Include diagnostic study and operative reports. <input checked="" type="checkbox"/> Most recent office visit notes. <input type="checkbox"/> Other, as specified _____				
<b>7. Is this patient <u>totally</u> disabled from his/her</b> <input type="checkbox"/> Sedentary <input type="checkbox"/> Light <input type="checkbox"/> Medium <input type="checkbox"/> Heavy <input type="checkbox"/> Very Heavy-Occupation of _____ <input type="checkbox"/> No, Date Released for RTW: _____ <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Yes, Project RTW Date: _____ <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time				
<b>8. Medically Necessary Restrictions/Limitations:</b>				
<b>9. Has Patient's condition:</b> <input type="checkbox"/> Recovered <input type="checkbox"/> Improved <input type="checkbox"/> Not Changed <input type="checkbox"/> Retrogressed			<b>10. Current</b> Disabling Diagnosis/ICD10 (code(s)) _____	
<b>11. Current</b> Objective Findings to Support Continued Total Disability (Please attach copies of diagnostic study reports if applicable):				
<b>12. Current</b> Treatment Plan (Please be specific, including surgeries (CPT codes)/procedures with dates, medications, therapy, etc.):				
<b>13. Did you refer patient to another physician for treatment or evaluation of the <u>current</u> disabling condition?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please provide: <div style="display: flex; justify-content: space-between;"> <span><u>Physician Name</u></span> <span><u>Specialty</u></span> <span><u>Address</u></span> <span><u>Phone Number</u></span> </div>				
<b>14. Physician Information:</b> Physician Name (Please Print): _____ Specialty: _____ Signature: _____ Date: ____/____/____ Address: _____ City: _____ State: _____ Zip: _____ Telephone Number: (____) _____ - _____ Fax Number: (____) _____ - _____ Email Address: _____				

**Authorization to Obtain Information  
(Medical records and other information)**

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The information obtained with this authorization may be used by Guardian to determine eligibility for benefits under The Insured's policy.

**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 or fail to sign this authorization or alter its content in any way, it may affect the handling of The Insured's claim, including the denial of benefits under The Insured's policy. Any information obtained will not be released by Guardian to any person or organization except to: affiliates (including but not limited to Berkshire Life Insurance Company of America); reinsuring companies; other persons (including but not limited to The Insured's attending medical provider), or insurance support organizations performing business or legal services in connection with The Insured's claim or application for insurance, or as may be otherwise lawfully required, or as I may further authorize. Information disclosed pursuant to this authorization is no longer covered by federal privacy rules and may be redisclosed pursuant to this authorization or as otherwise permitted or required by law. In the event that my coverage with Guardian requires me to pursue benefits available from the Social Security Administration, I further authorize Guardian to disclose information contained in my claim file with third parties specializing in social security disability claims.

**I, the undersigned, UNDERSTAND** that I have the right to revoke this authorization in writing at any time by sending a written request for revocation to Guardian at P.O. Box 14331, Lexington, KY 40512. I understand that a revocation is not effective to the extent that Guardian has already relied on this authorization, or to the extent that the company has a legal right to contest a claim under an insurance policy or to contest the policy itself.

**I, the undersigned, AGREE** that a photocopy of this form is as valid as the original, and I may request one. This form is valid up to 24 months (12 months in Kansas) from the date shown below.

**I, the undersigned, AUTHORIZE** the Social Security Administration to release information or records about (The Insured) to Guardian or its authorized representative or third parties. This information is to be released in order to properly adjudicate The Insured's claim or continue The Insured's eligibility for benefits. Please release detailed earnings for up to the last ten years and/or summary record of total earnings and/or information from master benefit records regarding award, denial or continuing benefits.

\_\_\_\_\_  
Signature of Insured (or authorized representative)

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Date

Name of Insured

Address

Claim #

Policy #

Date of Birth    /    /

## Fraud Warning Statements

**I, the undersigned, UNDERSTAND some states require that I be informed that:** 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 fraudulent insurance act, which is a crime and subject to criminal prosecution, substantial civil penalty and the stated value of the claim for each violation. By my signature below I acknowledge that I have read and am bound by the state specific fraud laws appearing below as may be applicable to me.

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Signature of Insured (or authorized representative)

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Relationship

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Date

### 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.

**Alaska:** A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

**Arkansas, West Virginia:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**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 information to obtain or amend insurance coverage or make a 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, Nebraska and Oregon:** 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.

**Idaho:** Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

**Kansas:** 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 insurance fraud as determined by a court of law.

**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 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.

**New York:** 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.

**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.

**Vermont:** 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.

**Virginia:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.