



Your Guide to Filing a Long Term Disability (LTD) Claim

We recognize how important it is for you to begin receiving the Long Term Disability (LTD) benefits to which you may be entitled. Guardian would like to make this process as easy as possible for you by providing all the forms and information you will need to initiate an LTD claim, so we can thoroughly review your case and make a timely decision.

To ensure this process goes smoothly, **it is imperative that you respond to all questions fully and accurately and send the forms back to us as soon as possible** -- you should not wait to file a claim until the elimination period has passed. The elimination period is the period of time between the onset of a disability and the time you are eligible for benefits.

How to Complete the Form

Please follow the instructions outlined below:

- **Section 1:** Claimant Statement – This section should be completed in full by you (the claimant).
- **Section 2:** Employer/Planholder Statement – This section should be provided to and completed in full by your company representative.
- **Section 3:** Attending Provider's Statement – You (the claimant) should complete the authorization section. The Attending Provider 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.

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

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.

The Guardian Life Insurance Company of America, 10 Hudson Yards, New York, NY 10001

If you are unable to provide a handwritten signature due to technical limitations resulting from the COVID-19 pandemic, Guardian will accept a typewritten name in lieu of your signature on an interim basis. You must check the box below each signature line certifying that you understand that your typewritten name has the same force and effect as your signature.

For **faster** service please:
 1. Complete this form on-line
 2. Print and physically sign it or use interim accommodation of typing your name in the signature line
 3. Save the completed form to your computer
 4. Upload via our [Secure Channel](#)

To mail this form:
 Guardian Group Long Term Disability Claims
 PO Box 14333 Lexington KY 40512
To fax the form:
 (610)-807-8221
Customer Service:
 1-800-538-4583

SECTION 1 - CLAIMANT STATEMENT

To be completed by the Employee/Member (Be sure to answer ALL questions – Failure to do so may delay your claim review)

INFORMATION ABOUT YOU

First Name	Middle Initial	Last Name	Social Security Number
Address of Residence		City	State Zip
Telephone #	Cell # or alternate #	E-mail Address	
Date of Birth (Month, Day, Year) : ____/____/____		<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Other legal union
Your employer: _____		Group Policy #: _____	Occupation: _____

Please indicate the extent of your formal education (circle one). This information is needed to evaluate return to work potential.
 Schooling Completed: 1 2 3 4 5 6 7 8 9 10 11 12 Diploma: Yes No GED: Yes No
 Vocational or Trade School: 1 2 3 4 Field of Study: _____ Certificate or license obtained Yes No
 College: 1 2 3 4 Degree: _____ Masters: Yes No Doctorate: Yes No
 Fields of Study _____

Briefly describe your past work experience for the last 20 years or attach resume. (Begin with your most recent job.)

Job Title	Duties	# of Years Worked
(a)		
(b)		
(c)		
(d)		

Spouse's First Name	Last Name	Date of Birth (Month, Day, Year)
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Do you authorize us to speak with someone other than yourself regarding your claim? Yes No If yes, advise of name, relationship and telephone # below:

Name	Relationship	Telephone #
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Do you have any dependent children? Yes No If yes, name and birth date of each child

Do you have an appointed Durable Power of Attorney to handle your financial affairs? Yes No If yes, please attach a copy.

INFORMATION ABOUT YOUR CLAIMED DISABILITY

Please provide the date you were first unable to work your regular work schedule due to your condition: ____/____/____ How many hours did you work that day? _____

Since that date, have you done any work? Yes No If yes, indicate dates worked, name of employer, and amount earned

Before you stopped working, did your condition require you to change your job, or the way you did your job? Yes No If yes, please explain:

What job duties are you unable to perform due to your condition and why?

If you have not returned to work, do you expect to? Yes No Unknown If yes, Part time (date) ____/____/____ Full time (date) ____/____/____. Would you be interested in vocational rehabilitation services to assist with your return to work? Yes No

What is or are your disabling condition(s)?

What were your first symptoms?

When did you first notice your symptoms? _____ Have you had this condition before? Yes No If yes, when?

Next to each Activity of Daily Living (ADL) listed below, please place the number that most accurately reflects your ability or inability to perform each activity:

1 = I can perform this activity independently;
 2 = I can perform this activity with the use of equipment or adaptive devices;
 3 = I cannot perform this activity.

____ Bathe (tub, shower, or sponge) ____ Transfer from bed to chair
 ____ Dress yourself ____ Voluntary bladder and bowel control or ability to maintain a reasonable level of personal hygiene
 ____ Use the toilet ____ Feed yourself with food that has been prepared and made available to you

Have you suffered a severe cognitive impairment that renders you unable to perform common tasks, such as using the phone, money management, or medication management? Yes No If yes, describe:

Date you were first treated by a physician for the condition for which you are claiming disability: ____/____/____

Name of Physician	Physician's Telephone #
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Is your condition related to your employment? Yes No If yes, please explain:

Have you filed, or do you intend to file a Workers' Compensation Claim? Yes No If yes, attach a copy of the award or denial.

If your disability was caused by an accident, answer the following questions:
 When, where and how did the accident occur?

If a police report was filed, attach a copy of the report. Do you intend to file suit regarding this accident? Yes No If yes, provide attorney name, address and telephone #:

INFORMATION ABOUT YOUR CARE AND TREATMENT

Family Physician Name	Specialty
Address	City State Zip
Telephone #	Fax #
Dates Seen: ____/____/____ to ____/____/____	

List all other physicians, pharmacy, and hospitals you have seen for your condition (attach separate sheet, if needed)

Physician Name	Specialty
Address	City State Zip
Telephone #	Fax #
Dates Seen: ____/____/____ to ____/____/____	

Physician name	Specialty
Address	City State Zip
Telephone #	Fax #
Dates Seen: ____/____/____ to ____/____/____	

Pharmacy Name	Telephone #	Fax #
Address	City	State Zip
Hospital Name	Dates of Hospitalization: ____/____/____ to ____/____/____	
Address	City	State Zip

OTHER INCOME/BENEFITS

Complete the sections below for any other income/benefits you have received/are receiving, or are eligible to receive during your disability. Please attach a copy of the award letter.

Source of income	Amount(week/month)	Date claim was filed	Date payments began	Date payments ended
Sick pay or salary continuation	\$ _____	N/A	_____	_____
Earnings from work while disabled	\$ _____	N/A	_____	_____
State Disability	\$ _____	_____	_____	_____
Short Term Disability	\$ _____	_____	_____	_____
Workers' Compensation	\$ _____	_____	_____	_____
No-Fault Insurance	\$ _____	_____	_____	_____
Social Security Disability	\$ _____	_____	_____	_____
Social Security Retirement	\$ _____	_____	_____	_____
Pension/Disability	\$ _____	_____	_____	_____
Pension/Retirement	\$ _____	_____	_____	_____
Unemployment	\$ _____	_____	_____	_____
Other _____	\$ _____	_____	_____	_____

Please contact us immediately if any of the above sources of income changes.

INFORMATION ABOUT TAX WITHHOLDING

Federal law requires us to withhold income tax from your check **only if you request us to do so**. We are also required to send a report to your employer at the end of each calendar year showing your name, total amount of benefits paid to you, total amount withheld, if any, and your social security number. If you want us to withhold tax, please indicate on the line below the whole dollar amount or percentage to be withheld per month. (Minimum of \$20.00)

\$ _____ .00 or _____ %

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.

* _____ Date ____ / ____ / ____

I am unable to provide a signature due to the COVID-19 pandemic. I understand that my typewritten name has the same force and effect as my signature.



Authorization to Obtain Information (Medical records and other information)

Send to: Group LTD Claims, P.O. Box 14333, Lexington KY 40512 Customer Service Toll Free: (800) 538-4583 Fax: (610) 807-8221
Documents can be returned electronically at www.guardianlife.com/forms. Select the "Benefits through work" option and click the "Secure Channel" link to send your private information.

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 14333, 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. A photocopy of this form is as valid as the original, and I may request one. I agree this authorization extends to all future requests, including records, past the date of the signature below. 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)

Date

Relationship of authorized representative

Name of insured

Name of authorized representative

Address

Date of Birth

Claim #

Policy #

Phone # of insured

Phone # of representative

Send to: Group Long Term Disability Claims, P.O. Box 14333, Lexington, KY 40512

For Customer Service: (800) 538-4583 Fax: (610) 807-8221

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

SECTION 2 - EMPLOYER/PLANHOLDER STATEMENT			
TO BE COMPLETED BY THE EMPLOYER/PLANHOLDER			
Employee/Member Name (Hereafter referred to as claimant)		Social Security Number	Date of Birth
Claimant's Address (Street, City, State, Zip)			Claimant's phone number
INFORMATION ABOUT THE EMPLOYER / PLANHOLDER			
Company's Name		Group Policy Number	
Address (Street, City, State, Zip)		Telephone Number	
Name and address of division where claimant works (if different from above)		Fax Number	
INFORMATION ABOUT THE CLAIMANT			
Date claimant was hired ____/____/____	Date claimant became insured under this plan ____/____/____	Insurance class:	Schedule at time last worked: ____ hours per day ____ days per week
Was the claimant insured under your prior LTD policy? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please provide the effective and termination dates of coverage: ____/____/____ Through ____/____/____			Name of prior carrier:
Has the claimant been terminated? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, date: ____/____/____ Reason:			
Would you be willing to rehire this person? <input type="checkbox"/> Yes <input type="checkbox"/> No Reason:			
Was the claimant on non-discriminatory family leave when disability began? <input type="checkbox"/> Yes <input type="checkbox"/> No Date leave of absence started under Family Leave Act ____/____/____ Did LTD insurance continue while on family leave? <input type="checkbox"/> Yes <input type="checkbox"/> No			
INFORMATION NEEDED FOR WITHHOLDING AND REPORTING TAXES			
Contributions to the cost of this insurance: ____% paid by employer <input type="checkbox"/> Check here if claimant elected a bonus back/gross up arrangement (IRS Ruling 2004-55) on a Post Tax basis ____% paid by claimant <input type="checkbox"/> Pre-Tax <input type="checkbox"/> Post-Tax			
INFORMATION ABOUT THE CLAIM			
What was the claimant's regular job?		How long had the claimant been performing his/her regular job?	
Was the claimant performing his regular job on his or her last day at work? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, Please explain _____ If no, how long had this claimant been performing this other job? _____			
Last day claimant worked ____/____/____	On that day, did the claimant work a full day? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, how many hours were worked? _____		
Reason for leaving work: <input type="checkbox"/> dismissed <input type="checkbox"/> leave of absence <input type="checkbox"/> disability <input type="checkbox"/> resigned <input type="checkbox"/> retired <input type="checkbox"/> layoff	Date claimant is expected/did return to work ____/____/____ Full time? <input type="checkbox"/> Yes <input type="checkbox"/> No Part time? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Is the claimant's condition work related? <input type="checkbox"/> Yes <input type="checkbox"/> No	Has a Workers' Compensation claim or similar claim been filed? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, send initial report of illness or injury and award notice.		
Name, address and phone number of that benefit provider			
INFORMATION ABOUT YOUR PENSION PLAN (Do not complete for maternity claim.)			
Do you have a pension plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, what type? (Check as many as applicable)	<input type="checkbox"/> Defined Benefit <input type="checkbox"/> 401 K <input type="checkbox"/> Other (specify)	<input type="checkbox"/> Defined Contribution <input type="checkbox"/> Profit Sharing
Is the claimant eligible for your pension plan? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, why?	If eligible, does the claimant participate? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, why?		
If the claimant is participating, when is he or she eligible for benefits under the plan? ____/____/____ Is there a Disability Retirement option available to this claimant? <input type="checkbox"/> Yes <input type="checkbox"/> No			
INFORMATION ABOUT YOUR JOB ACCOMMODATION OR RETURN-TO-WORK POLICIES			
Does your company have a job-holding policy? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain _____			
What is the name, title, and telephone number of the person we should contact to discuss return to work or job accommodation opportunities?			

INFORMATION ABOUT THE CLAIMANT'S SALARY

Average earnings excluding bonus, overtime and special compensation as of the most recent redetermination date:

\$ _____ Week Month Year

Date of last salary increase ____/____/____

Claimant is paid:

- hourly Salary W2 earnings _____
 by partnership commissions only* salary & commissions*
 salary & bonus* salary & commissions*

*Please provide average of bonus and commissions for 24 months preceding your plan's most recent redetermination date

Is this claimant eligible for salary continuation?

Yes No If Yes, what is the weekly amount? \$ _____ When did benefits begin? ____/____/____ End? ____/____/____

Has the claimant filed for Short Term Disability or State Disability benefits?

Yes No If Yes, what is the weekly amount? \$ _____ When did benefits begin? ____/____/____ End? ____/____/____

List any other sources of income to which the claimant is entitled as a result of this disability:

Information about the physical aspects of the claimant's job

Check the items below that relate to the claimant's job and complete the information requested. Use these definitions for the frequency of occurrences in an eight hour day

- **Not Applicable** means the person does not perform this activity
- **Frequently** - 2 ½ hours up to 5 ½ hours
- **Occasionally** - 15 minutes up to 2 ½ hours
- **Continuously** - 5 ½ hours and beyond

Frequency of Occurrence

Activity	N/A	Occasionally	Frequently	Continuously
<input type="checkbox"/> Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Balancing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Bending	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Kneeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Crouching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Crawling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Reaching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Working overhead	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Keyboard Use/Repetitive Hand Motion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Climbing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Driving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Activity	Description	Frequency	Weight
<input type="checkbox"/> Pushing	_____	_____	_____ lbs.
<input type="checkbox"/> Pulling	_____	_____	_____ lbs.
<input type="checkbox"/> Lifting	_____	_____	_____ lbs.
<input type="checkbox"/> Carrying	_____	_____	_____ lbs.

Stress level Low Moderate High Very high

Can the job be performed by alternating sitting and standing? Yes No

Claimant must use hands for repetitive action such as:

	Right		Left	
Simple grasping	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Firm grasping	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fine manipulation	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Use feet for repetitive movements as in operating foot controls:

Right Yes No Left Yes No Both Yes No

REQUIRED ATTACHMENTS AND SIGNATURE

Please attach a copy of the claimant's job description.

If salary is based on a W-2, K-1, 1099 or a similar document, attach a copy of the most recent document.

If you have medical information from the claimant's file relating to this disability, please attach copies.

If a work related claim is filed, send a copy of the initial report of injury or illness and award notice.

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.

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Name (Please print or type) Title Email Address

Signature Date

Send to: Group Long Term Disability Claims, P.O. Box 14333, Lexington, KY 40512

For Customer Service: (800) 538-4583 Fax: (610) 807-8221

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SECTION 3 - ATTENDING PROVIDER'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
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THIS PART TO BE COMPLETED BY THE ATTENDING PROVIDER

THIS PART TO BE COMPLETED BY THE ATTENDING PROVIDER

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 Single Birth Multiple Births

DIAGNOSIS

Primary diagnosis: _____ ICD-9/10 Code: _____
 Secondary diagnosis(es): _____ ICD-9/10 Code: _____
 Subjective symptoms: _____
 Physical examination findings: _____
 Test results (list all results, or enclose test):
 Test: _____ Date: _____ Results: _____
 Test: _____ Date: _____ Results: _____

TREATMENT

Date of onset of this condition: ____/____/____	Date you first treated this patient for this condition: ____/____/____
Date of most recent visit: ____/____/____	Date of next office visit: ____/____/____
Frequency of visits/treatment for this condition: <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other _____	
Was patient referred to you by another physician? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide name, address, phone # and fax #:	
Have you referred this patient to any other physician? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Date(s): ____/____/____ ____/____/____	
Physician Name	Specialty
Address (Street, City, State, Zip)	Phone #
Describe treatment plan (Include medication, therapy, counseling, rehab, etc.):	
Has surgery been performed? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Date: ____/____/____ Procedure: _____ CPT Code: _____	
Was patient hospitalized for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Date(s) admitted: ____/____/____ Date(s) discharged: ____/____/____	
Name of Hospital	
Address	City State Zip
Progress (please check one): <input type="checkbox"/> Recovered <input type="checkbox"/> Improved <input type="checkbox"/> Unchanged <input type="checkbox"/> Retrogressed Patient is (please check one): <input type="checkbox"/> Ambulatory <input type="checkbox"/> Bed confined <input type="checkbox"/> House confined <input type="checkbox"/> Hospital confined <input type="checkbox"/> Nursing Home/Assisting Living confined <input type="checkbox"/> Other _____	

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 REPORTS AND MENTAL STATUS EXAM (IF APPLICABLE). THIS WILL HELP TO EXPEDITE THE CLAIM PROCESSING AND REDUCE ADDITIONAL REQUESTS AND FOLLOW UP.

Provider'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 Provider (no stamp)

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.

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 a false or fraudulent 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.