

SIGNATURE OF PHYSICIAN _

Group Short Term Disability Claim

To expedite your claim review, STD claims may be filed on-line by visiting us at www.guardiananytime.com.

Or, you may complete the form and submit by fax to (610) 807-8270 or email to group_std_claims@glic.com You may also send to: Group STD Claims, P.O. Box 14331, Lexington, KY 40512 Customer Service toll-free: 1-800-268-2525 EMPLOYEE SECTION - PLEASE PRINT AND COMPLETE IN FULL TO PREVENT DELAY IN PROCESSING 1 EMPLOYEE NAME 2 EMPLOYER NAME 4 EMPLOYEE HOME MAILING ADDRESS CITY STATE 5. EMPLOYEE TELEPHONE NUMBER EMPLOYEE EMAIL ADDRESS 6. DATE OF BIRTH 10. NUMBER OF 7. SOCIAL SECURITY NUMBER 8. ☐ MALE ☐ SINGLE ■ MARRIED □ WIDOWED **DEPENDENTS** ☐ FEMALE □ LEGALLY SEPARATED □ DIVORCED **UNDER AGE 18** 11. IS DISABILITY DUE TO YOUR EMPLOYMENT? ☐ YES ☐ NO 12. IS DISABILITY DUE TO AN ACCIDENT? ☐ YES IF "YES", HAVE YOU FILED A WORKERS' COMPENSATION CLAIM? ☐ YES ☐ NO IF "YES". DO YOU INTEND TO FILE SUIT? ☐ YES DISABILITY DUE TO SERVICE IN THE MILITARY? ☐ YES 14. DATE SYMPTOMS FIRST APPEARED 15. RETURN TO WORK DATE ☐ ACTUAL 13. IF YOU ANSWERED "YES" TO QUESTION (11) AND/OR (12), PLEASE PROVIDE THE FOLLOWING □ POSSIBLE DATE OF ACCIDENT / / TIME ACCIDENT DETAILS 16. ARE YOU ELIGIBLE TO RECEIVE ANY OTHER INCOME (SOCIAL SECURITY, WORKERS' COMPENSATION, STATE DISABILITY, PENSION, NO-FAULT, ASSOCIATION/INDIVIDUAL DISABILITY PLANS AND SALARY CONTINUATION AND/OR SICK LEAVE BENEFITS, ETC.)? SOURCE (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 PLEASE NOTE: CERTAIN DISABILITY BENEFITS ARE CONSIDERED SUPPLEMENTAL WAGES BY THE IRS (SEE IRS PUBLICATION 15A). IF YOUR DISABILITY BENEFIT IS DETERMINED TO MEET THESE REQUIREMENTS, A MANDATORY FEDERAL INCOME TAX WITHHOLDING (22%) IS REQUIRED. IF YOUR CLAIM IS PAYABLE, GUARDIAN WILL ADVISE YOU AT TIME OF PAYMENT IF THIS MANDATORY WITHHOLDING APPLIES TO YOUR BENEFIT PAYMENTS. 18. 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." "Please Note: Your Social Security number is required for IRS tax reporting purposes. Your Social Security number will not be used or disclosed to anyone for any other purpose and will not be retained in any record other than that pertaining to the claim. PLEASE NOTE: THE ATTACHED HIPAA AUTHORIZATION MUST BE COMPLETED SIGNATURE OF EMPLOYEE PHYSICIAN SECTION – PLEASE COMPLETE IN FULL AND RETURN TO PREVENT DELAY IN PROCESSING 1. DIAGNOSIS(ES) 2. ICD-10 CODE(S) 3. IS PATIENT'S DISABILITY DUE TO A) EMPLOYMENT | TYES | TNO B) ACCIDENT IT YES IT NO C) PREGNANCY ☐ YES ☐ NO D) MILITARY SERVICE ☐ YES ☐ NO 4. IF DISABILITY IS DUE TO PREGNANCY, PLEASE INDICATE DATE OF DELIVERY **ESTIMATED** (IF UNDELIVERED) PLEASE INDICATE TYPE OF DELIVERY □ VAGINAL □ C-SECTION 5. DATE SYMPTOMS FIRST APPEARED 6. DATE OF FIRST VISIT FOR THIS CONDITION 7. A) DATES OF TREATMENT FOR THIS CONDITION HEIGHT 7. B) DATE OF PATIENT'S NEXT APPOINTMENT 9. DATE PATIENT WAS TOTALLY DISABLED (UNABLE TO WORK) WEIGHT LBS FROM / / THROUGH 10 IF PATIENT STILL DISABLED GIVE DATE FOR 11. DATES PATIENT WAS HOSPITALIZED (IF APPLICABLE) ANTICIPATED RELEASE TO RETURN TO WORK / / THROUGH / / 12. SURGICAL DATE(S) CPT(S)/PROCEDURE(S) 14. A) WAS PATIENT REFERRED TO YOU BY ANOTHER PHYSICIAN? ☐ YES ☐ NO 13. A) WOULD YOU SUPPORT THE PATIENTS RETURN TO WORK ON A LIMITED BASIS? IF "YES", PLEASE GIVE NAME AND TELEPHONE NUMBER OF PHYSICIAN ☐ YES ☐ NO IF "YES", PLEASE PROVIDE RESTRICTIONS AND LIMITATIONS THAT WOULD BE IN PLACE 14. B) DID YOU REFER PATIENT TO ANOTHER PHYSICIAN? $\ \square$ YES $\ \square$ NO IF "YES", PLEASE GIVE NAME AND TELEPHONE NUMBER OF PHYSICIAN 13. B) DURATION OF ABOVE RESTRICTIONS: 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 (____ EMAIL ADDRESS FAX NUMBER (TAX ID #

DATE



EMPLOYER	SECTI	ON – PLEASE P	RINT AND COMI	PLETE <u>IN F</u>	JLL (C	UESTIONS 1	<u>-24</u>) TO	PREVEN	T DELAY IN F	ROCES	SING		
1. EMPLOYER NAME Dodge County Board of Education				ion					2. PLAN NUMB 55047	AN NUMBER 550470			
3. EMPLOYER AI		e Street					CITY E	Castm	an	STATE	GA ZIP 3	31023	
720 66	720 College Street												
							STATE						
IF BRANCH OR AFFILIATE, PLEASE PROVIDE NAME OF PARENT EMPLOYER S COMPANY						ZIP CIAL SECURITY OR TAX ID 4. DATE E / /				MPLOYEE TERMINATED/RESIGNED			
5. EMPLOYEE NAME				7. EMPLOYEE SOO SECURITY NUM							B. EMPLOYEE DATE OF BIRTH / /		
9. EMPLOYEE JOB TITLE				10. DATE 0	DF EMPL	OYMENT.	11. DA	TE EMPLOY	EE EFFECTIVE FO	OR STD	12. EMPLOYEE INSURANCE CLASS		
13. ACTUAL LAST DAY WORKED			14. NORMAL WORK	K SCHEDULE:		ON TUES	WED	THURS	FRI SAT	SUN	HOURS	S/WEEK S/DAY	
15. HOURS WORKED ON LAST DAY 16. REAS				REASON FOR LEAVING WORK:									
17. CAN THE EMP	PLOYEE'S J	OB BE MODIFIED TO	ALLOW FOR RETURN	I TO WORK?	18. DA	TE EMPLOYEE RETURNED TO WORK					□ PART TIME		
☐ YES ☐ NO ☐ MAYBE, DEPENDING ON RESTRICTIONS									/ /		☐ FULL TIME		
19. SALARY – PLEASE PROVIDE:										□ WEEK			
EMPLOYEE'S BASE SALARY (<u>DO NOT INCLUDE BONUS</u> , 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 NO OR TO RECEIVE A CALL FROM OUR 1. FROM / / 10 / / 1. FROM / / 10 / / 1. FROM / / 10 / / 21. FOR ASSISTANCE WITH JOB ACCOMMOCATION STAY AT WORK OPPORTUNITIES, CONTACT OUR VOCATIONAL REHABILITATION DEPT. AT 800-233-0691, OR, TO RECEIVE A CALL FROM OUR													
		RE TO COMPLETE TH	VOC REHAB DEPT., PLEASE PROVIDE US WITH THE PERSON YOU WOULD LIKE US TO CONTACT:										
% PAID BY EMPLOYEE,						NAME:							
SUPPLEMENTAL WAGES BY THE IRS (SEE IRS PUBLICATION 15A). IF YOUR DISABILIT PLAN IS SELF FUNDED, GUARDIAN WILL DEDUCT A MANDATORY 25% FEDERAL INCO TAX WITHHOLDING FROM THE DISABILITY BENEFIT CHECKS THAT ARE ISSUED.						PHONE:							
		ARISE OUT OF EMPLO			F "YES",	PLEASE EXPLAIN	N						
			BEEN FILED? YE		a4 4h	e physical so		i the elei	mantla iah aa		and in an O	harra mante dan	
23. JOB DESCRIP	P P	lease also attacl	lete the followin h a description o	f job duties	, if ava	ilable.	pects of	the cian	nant's Job as	periorii	ieu in an o	nour work day.	
	NEVER	OCCASIONALLY .25 – 2.5 DAILY HRS	FREQUENTLY 2.5 – 5.5 DAILY HRS	CONTINUOU 5.5 – 8 DAIL HRS				NEVER	OCCASIONALLY .25 – 2.5 DAILY HRS		EQUENTLY - 5.5 DAILY HRS	CONTINUOUSLY 5.5 – 8 DAILY HRS	
SIT						WALF	<						
STAND						DRIVI	E						
LIFT/CARRY	INDICATE AMOUNT/FREQUENCY BELOW					REACH AI	BOVE						
0-10 LBS						BEND/ST	OOP						
10-20 LBS						USE HAND	S FOR		INDICATE A	CTIVITY/F	REQUENCY BE	ELOW	
20-50 LBS						PUSHING/P	ULLING						
50-100 LBS						FINE MANIPU	JLATION						
OVER 100 LBS						STRESS LEVEL							
24. 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 TILE TELEPHONE NUMBER () - EXT FAX NUMBER () - EMAIL ADDRESS													



Authorization to Obtain Information (Medical records and other information)

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.GuardianAnytime.com. Click on "Secure Channel" on the Guardian Anytime home page.

- 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, 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."
- I, the undersigned, AGREE the information obtained with this authorization may be used by Guardian to determine eligibility for benefits under The Insured's policy. 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. I declare that all answers, statements and information made or given by me, or at my direction, in connection with this claim are and have been complete and true.

complete and true.						
Signature of Insured (or authori	zed representative)	Relationship		 Date		
Name of Insured						
Address						
Claim #	Policy #		Date of Birth / /			

GG-013843 (7/16)





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: 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 quilty 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.

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 quilty 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.

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: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.