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.

Guardian The Guardian Life Insurance Company of America Application for Long Term Disability Benefits

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) : _____/_____/_____ ☐ Male ☐ Female ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ 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)

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 #

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 #

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.

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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.

_____ _____

Handwritten Signature of insured (or authorized representative) **Handwritten Date**

_____ _____

Name of authorized representative **Relationship of authorized representative**

Name of insured

Date of Birth

Phone # of insured

Address

Claim #

Policy #

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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? ☐ Yes ☐ No If Yes, please provide the effective and termination dates of coverage: _____/_____/_____ Through _____/_____/_____ Name of prior carrier:

Has the claimant been terminated? ☐ Yes ☐ No If Yes, date: _____/_____/_____ Reason:

Would you be willing to rehire this person? ☐ Yes ☐ No Reason:

Was the claimant on non-discriminatory family leave when disability began? ☐ Yes ☐ No
Date leave of absence started under Family Leave Act _____/_____/_____
Did LTD insurance continue while on family leave? ☐ Yes ☐ No

INFORMATION NEEDED FOR WITHHOLDING AND REPORTING TAXES

Contributions to the cost of this insurance:
_____% paid by employer ☐ Check here if claimant elected a bonus back/gross up arrangement (IRS Ruling 2004-55) on a Post Tax basis
_____% paid by claimant ☐ Pre-Tax ☐ 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? ☐ Yes ☐ 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? ☐ Yes ☐ No If No, how many hours were worked? _____

Reason for leaving work: ☐dismissed ☐ leave of absence ☐ disability ☐resigned ☐ retired ☐ layoff	Date claimant is expected/did return to work _____/_____/_____ Full time? ☐ Yes ☐ No Part time? ☐ Yes ☐ No

Is the claimant's condition work related? ☐ Yes ☐ No	Has a Workers' Compensation claim or similar claim been filed? ☐ Yes ☐ 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? ☐ Yes ☐ No	If Yes, what type? (Check as many as applicable)	☐ Defined Benefit ☐ Defined Contribution	☐ 401 K ☐ Profit Sharing	☐ Other (specify)

Is the claimant eligible for your pension plan? ☐ Yes ☐ No If No, why?	If eligible, does the claimant participate? ☐ Yes ☐ 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? ☐ Yes ☐ No

INFORMATION ABOUT YOUR JOB ACCOMMODATION OR RETURN-TO-WORK POLICIES

Does your company have a job-holding policy? ☐ Yes ☐ 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**
☐ Standing	☐	☐	☐	☐
☐ Walking	☐	☐	☐	☐
☐ Sitting	☐	☐	☐	☐
☐ Balancing	☐	☐	☐	☐
☐ Bending	☐	☐	☐	☐
☐ Kneeling	☐	☐	☐	☐
☐ Crouching	☐	☐	☐	☐
☐ Crawling	☐	☐	☐	☐
☐ Reaching	☐	☐	☐	☐
☐ Working overhead	☐	☐	☐	☐
☐ Keyboard Use/Repetitive Hand Motion	☐	☐	☐	☐
☐ Climbing	☐	☐	☐	☐
☐ Driving	☐	☐	☐	☐

Activity	**Description**	**Frequency**	**Weight**
☐ Pushing	_____	_____	_____ lbs.
☐ Pulling	_____	_____	_____ lbs.
☐ Lifting	_____	_____	_____ lbs.
☐ 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	☐ Yes	☐ No	☐ Yes	☐ No
Firm grasping	☐ Yes	☐ No	☐ Yes	☐ No
Fine manipulation	☐ Yes	☐ No	☐ Yes	☐ 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.

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.

_____ Name (Please print or type)
_____ Title
_____ Email Address

_____ Signature
_____ Date

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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

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: ☐ Weekly ☐ Monthly ☐ Other _____
Was patient referred to you by another physician? ☐ Yes ☐ No If yes, provide name, address, phone # and fax #:
Have you referred this patient to any other physician? ☐ Yes ☐ 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? ☐ Yes ☐ No If yes, Date: ____ /____ / ____ Procedure: _____ CPT Code: _____
Was patient hospitalized for this condition? ☐ Yes ☐ No If yes, Date(s) admitted: ____ /____ / ____ Date(s) discharged: ____ /____ / ____
____ /____ / ____ ____ /____ / ____
Name of Hospital
Address | City | State | Zip
Progress (please check one): ☐ Recovered ☐ Improved ☐ Unchanged ☐ Retrogressed
Patient is (please check one): ☐ Ambulatory ☐ Bed confined ☐ House confined ☐ Hospital confined
☐ Nursing Home/Assisting Living confined ☐ 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.